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ARTICLE I - DEFINITIONS

ADMINISTRATIVE PHYSICAL EXAMINATIONS means limited, focused evaluations performed for the purpose of obtaining or maintaining employment, insurance, governmental licensure, attending camp, participating in sports, admissions to school, for premarital purposes or adoption.

ANNUAL/SCREENING EXAMS means Coverage is available for a service no sooner than eleven months from the previous service.

BIOLOGIC PRODUCTS mean those products licensed and approved under the FDA's Center for Biologic Evaluation and Research (CBER) including: vaccines (including therapeutic vaccines), blood, blood products or components (i.e., recombinant blood clotting factors, immunoglobulins, alpha-1 proteinase inhibitors), products composed of human or animal cells or physical parts of those cells, viruses, therapeutic serums, vectors, genes, other genetic components (i.e., gene therapy), allergenics, allergen patch tests, antitoxins, antivenins, venoms, toxoids, toxins (for immunization) and in vitro diagnostics.

BIOPHARMACEUTICAL DRUGS mean drugs manufactured through advanced technologies including biotechnology methods involving live organisms or derived functional components (bioprocessing) approved and regulated under the FDA's Center for Drug Evaluation and Research (CDER) intended for the prevention, treatment or cure of disease/condition in human beings.

Biopharmaceutical Drug product categories include:

1. monoclonal antibodies for *in vivo* use,
2. proteins intended for therapeutic use including cytokines, enzymes or other novel proteins,
3. immunomodulators (non-vaccines and blood products) including proteins derived from plants, animals, or microorganisms, and recombinant versions of these products,
4. growth factors, cytokines, and monoclonal antibodies intended to mobilize, stimulate, decrease or otherwise alter the production of hematopoietic cells *in vivo*, and
5. therapeutic synthetic peptide products of 40 or fewer amino acids.
6. drugs developed through advanced technology that are not included under item "a" above. The Pharmacy and Therapeutics committee will assign drugs to this category based on cost and the need to provide exceptional management such as:
 - a. Prior Authorization, and
 - b. provision through a network selected specialty pharmacy vendor, and,
 - c. clinical oversight, and/or
 - d. disease management, and/or
 - e. case management.

CALENDAR YEAR is the one-year period from January 1st through December 31st of a given year.

CHEMICAL DEPENDENCY/SUBSTANCE ABUSE SERVICES are services and supplies for the diagnosis and treatment of alcoholism and Chemical Dependency disorders which are listed in the Diagnostic and Statistical Manual-IV or any revision thereof. The fact that a disorder is listed in the Diagnostic and Statistical Manual-IV does not mean that treatment of the disorder is Covered under the Group Service Agreement.

COINSURANCE means those amounts which are paid by the Covered Person as a percentage of Eligible Expenses, if applicable. The Coinsurance amounts are applied to Eligible Expenses incurred after any applicable deductible has been met and before any applicable out-of-pocket maximum has been met.

CONTRACT YEAR is the one-year period determined by the Employer Group and the Plan during which benefits are effective and which may not be a calendar year. (For example, if an employer's effective date is July 1st, then the Contract Year is July 1st of that year through June 30th of the following year.)

CONVENTIONAL MEDICINE is the provision of Health Care Services as provided by a Physician and by health care professionals, such as physical therapists, psychologists and registered nurses in accordance with accepted standards of medical practice.

COPAYMENT means the defined dollar amount the Covered Person is required to pay for certain Health Care Services provided under the Group Service Agreement. The Covered Person is responsible for the payment of any Copayment directly to the provider of the Health Care Services at the time of service.

COSMETIC PROCEDURES are those procedures which improve physical appearance, and do not correct or materially improve a physiological function and are not Medically Necessary.

COVERAGE or **COVERED** is the entitlement by a Covered Person to Health Care Services provided under the Group Service Agreement, subject to the terms, conditions, limitations and exclusions.

COVERED PERSON or **MEMBER** As per **Agreement for Prepaid Health Care and Administrative Services, January 1, 2007**; Section V, Eligibility, Enrollment and Effective Date, Sub-Section A as follows.

Eligibility

1. All active full-time (37½ hours per week) employees and their eligible "dependents".
2. All appointed or elected officials and their eligible "dependents".
3. Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.
4. "Dependent" means:
 - a. Spouse of an employee;
 - b. Any unmarried dependent children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an educational institution). Such child shall remain a "dependent" until marriage or the end of the calendar year in which he/she attains age 19/23. In the event a child who is a "dependent" as defined herein, is both
 - i. incapable of self-sustaining employment by reason of mental or physical disability and
 - ii. is chiefly dependent upon the employee for support and maintenance;prior to age 19, such child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "dependent" will continue until the employee discontinues his coverage or the disability no longer exists. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires annual documentation from a physician after the child's attainment of the limiting age.
5. A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Legislator" who meets the following:
 - a. Is no longer a member of the General Assembly;
 - b. Who served as a legislator for at least 10 years.

A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's spouse covered under the health insurance program. In addition, the surviving spouse of a legislator who has died may elect to participate in the group health insurance program if all of the following apply:

- i. The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the date of the legislator's death;
- ii. The surviving spouse files a written request for insurance coverage with the employer;
- iii. The surviving spouse pays an amount equal to the employer's and employee's premium for the group health coverage for an active employee.

The eligibility of the retired legislator's spouse, or a surviving spouse of a legislator for group health coverage is not affected by the death of the retired legislator and is not affected by the retired legislator's eligibility for Medicare. The spouse's eligibility ends on the earliest of the following:

- i. When the employer terminates the health coverage program;
- ii. The date of the spouse's remarriage;

"Dependent" for a "Retired Legislator" means an unmarried person who:

- i. Is a dependent child, stepchild, foster child, or adopted child of a former legislator or spouse of a former legislator or a child who resides in the home of a former legislator or spouse of a former legislator who has been appointed legal guardian for the child; and
- ii. Is less than twenty-three (23) years of age; at least twenty-three (23) years of age, incapable of self-sustaining employment by reason of mental or physical disability, and is chiefly dependent on a former legislator or spouse of a former legislator for support and maintenance; or at least twenty-three (23) years of age and less than twenty-five (25) years of age and is enrolled in and is a full-time student at an accredited college or university.

6. "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

- a. Must retire before January 1, 2007;
- b. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
- c. Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;
- d. Must have fifteen (15) years of participation in a retirement fund.

7. "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

- a. Must retire after December 31, 2006.
- b. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
- c. Must have completed fifteen (15) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement.

8. "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

- a. Must have been employed as a teacher in a State institution under IC 11-10-5, IC 12-24-3, IC 16-33-3, or IC 16-33-4;
- b. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
- c. Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement;

9. A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:

- a. Retirement date is after June 30, 1990;

- b. Will have reached the age of sixty-two (62) on or before retirement date;
 - c. Is not eligible for Medicare coverage as prescribed by 42 U.S.C 1395 et seq.;
 - d. Who has at least eight (8) years of service credit as a participant in the judge's retirement fund, with at least eight (8) years of that service credit completed immediately preceding the judge's retirement.
10. A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:
- a. Who is a retired participant under the Prosecuting Attorneys' Retirement fund;
 - b. Whose retirement date is after January 1, 1990;
 - c. Who is at least sixty-two (62) years of age;
 - d. Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
 - e. Who has at least ten (10) years of service credit as a participant in the prosecuting attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.
11. Retirees eligible under subsections 6-10 must file a written request for the coverage within ninety (90) days after retirement. At that time, the retiree may elect to have the retiree's spouse covered. The spouse's subsequent eligibility to continue insurance under the surviving spouse's eligibility ends on the earliest of the following:
- a. Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the spouse would be eligible to remain covered until the end of the maximum period under COBRA;
 - b. When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C 1395 et seq.;
 - c. The end of the month following remarriage; or
 - d. As otherwise provided in I.C.5-10-8-8 (g).
12. Employee on a leave of absence for ninety (90) days or less and out of pay status.
13. An employee on family leave.
14. Retirees eligible under IC 5-10-12.
15. For legislator, Dependent or spouse as defined and pursuant to the conditions set forth in I.C.5-10-8-8.2.
16. All active and retired full-time and part-time employees, elected or appointed officers and officials of a local unit of government that elect to provide health coverage under this plan. A local unit of government is defined as follows:
- a. A city, town, county, township, public library, or school corporation
 - b. Any board, commission, department, division, authority, institution, establishment, facility, or governmental unit under the supervision of either the state or a city, town, county, township, public library, or school corporation, having a payroll in relation to persons it immediately employs, even if it is not a separate taxing unit.
17. As otherwise provided by Act of the Indiana General Assembly.

CUSTODIAL CARE means non-health related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing, such services and supplies are custodial without regard to the practitioner or provider by whom or by which they are prescribed, recommended, or performed and without regard to whether they are performed by individuals who are trained or licensed medical or nursing personnel, which include but are not limited to the following: assistance in activities of daily living; transportation; meal preparation; or companion activities.

DURABLE MEDICAL EQUIPMENT is equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of a sickness or injury and is appropriate for use in the home, provided however, that such items shall not include equipment for use in altering air quality or temperature, equipment for use in exercise or training, or equipment that is not normally of use to a person who does not have an injury or disease.

ELIGIBLE DEPENDENT means:

1. Spouse of an employee;
2. Any unmarried dependent children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an educational institution). Such child shall remain a "dependent" until marriage or the end of the calendar year in which he/she attains age 19/23. In the event a child who is a "dependent" as defined herein, is both
 - a. incapable of self-sustaining employment by reason of mental or physical disability, and
 - b. is chiefly dependent upon the employee for support and maintenance;prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "dependent" will continue until the employee discontinues his coverage or the disability no longer exists. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires annual documentation from a physician after the child's attainment of the limiting age.

ELIGIBLE EXPENSES are what the Plan or Network would pay Participating Providers for Health Care Services Covered under the Group Service Agreement (GSA) while the GSA is in effect, except that Eligible Expenses for Emergency and Urgent Care Services provided by non-participating network providers would be equal to the Usual and Customary Charges.

ELIGIBLE PERSON means any person eligible to enroll as a Subscriber under the Agreement as defined by the Group and agreed to by the Plan, and as indicated on the Application for Group Service Agreement and as further described in Article III, Section A.

EMERGENCY SERVICES or **MEDICAL EMERGENCY** means medical services that arise suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

1. Place an individual's health in serious jeopardy;
2. Result in serious impairment to the individual's bodily functions; or
3. Result in serious dysfunction of a bodily organ or part of the individual.

ENROLLMENT means the act of completing an Enrollment Application including designating a Primary Care Physician. A Primary Care Physician must be indicated for each Covered Person in order for the benefits of this Plan to apply to such a Covered Person under this Agreement.

ENROLLMENT APPLICATION means the application for Enrollment in the Plan which must be completed and signed by the Subscriber providing necessary information for the Plan, listing all Eligible Dependent(s) who are to become Covered Persons hereunder on the Individual Effective Date, and, indicating the Covered Person's choice of a Primary Care Physician.

EXPERIMENTAL TREATMENT means medical technology or a new application of existing medical technology, including medical procedures, drugs and devices for treating a medical condition, illness or diagnosis that:

1. Is not generally accepted by informed health care professionals in the United States as effective; or
2. Has not been proven by scientific testing or evidence to be effective in treating the medical condition, illness or diagnosis for which its use is proposed.

See Article VIII for decision-making criteria.

FAMILY means the Subscriber and his or her Covered Eligible Dependents.

FRAUD or FRAUDULENT ACTS, if committed by the Member or any Eligible Dependent(s), means:

1. allowing the use of a Membership Card to obtain services, or
 2. making any false statements or representations on his or her membership application; or
 3. falsifying a prescription, stealing or otherwise misappropriating a prescription blank(s) or other property of a Participating Provider of the Plan; or
 4. altering his or her medical record; or
 5. obtaining similar drug therapy or prescriptions from two (2) or more providers, without the proper referral or without informing the providers of the Member's or Eligible Dependent(s) complete prescription profile
- and will result in the termination of the Member and any Eligible Dependents.

FULL-TIME STUDENT means an Eligible Dependent who is enrolled in and attending, full-time, a recognized course of study or training at:

1. An accredited high school or vocational school; or
2. An accredited college or university; or
3. A licensed technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. A person continues to be a Full-time Student during periods of vacation established by the institution.

GROUP or EMPLOYER GROUP is the body of Subscribers eligible for Group insurance by virtue of some common identifying attribute, such as common employment by an employer or a membership in a union, association or other organization.

GROUP SERVICE AGREEMENT or AGREEMENT means this Exhibit regarding the benefits, exclusions and other conditions between the Plan (M•Plan, Inc.) and the Group.

HEALTH CARE SERVICES means

1. any services provided by individuals licensed under IC 25-10, IC 25-13, IC 25-14, IC 25-22, IC 25-23, IC 25-26, IC 25-27, IC 25-29, IC 25-33 or IC 25-35.6;
2. services provided as a result of hospitalization;
3. services incidental to the furnishing of services described in subdivision (1) or (2); or
4. any other services of goods furnished for the purpose of preventing, alleviating, curing or healing human illness, physical disability or injury.

HOME HEALTH CARE means a program of care provided by a public agency or private organization or a subdivision of such an agency or organization which is primarily engaged in providing skilled nursing service and other therapeutic services in the homes or places of residence of its patients; which has policies, established by a group of professional personnel associated with agency or organization, including one or more Physicians and one or more registered nurses to govern the services which it provides, and provides for the supervision of such services by a Physician or registered professional nurse; and which maintains clinical records of all patients.

HOSPICE CARE means a program designated to provide care for the terminally ill who have a medical prognosis of a life expectancy of six months or less, through a Medicare approved Hospice program. Hospice Care must be directed by professional medical personnel licensed within the state in which they practice. The treatment is intended to enhance comfort and improve the quality of the patient's life and emphasizes pain and symptom control rather than curative care for terminally ill patients in the final weeks and months of a patient's life.

HOSPITAL means an acute general Hospital which provides inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of one or more duly licensed Physicians; which provides continuous nursing service by or under the supervision of registered professional nurses; and is not a federal Hospital nor a place for the aged, nor a Skilled Nursing Facility, nor a nursing home, nor an institution of rehabilitation; and which is an institution which operates as an acute general Hospital pursuant to applicable state or Federal laws.

HOSPITAL INPATIENT means a Member formally admitted to a Hospital as ordered by a Physician or other individual authorized by the state licensure law and Hospital staff bylaws, and to whom a bed and board charge will apply.

IMMEDIATE CARE/URGENT CARE CENTER is a facility that provides Coverage for Covered Persons who are referred for Immediate Care/Urgent Care Services by their Primary Care Physician.

IMMEDIATE CARE/URGENT CARE SERVICES means medical care for an unforeseen illness or injury that is not life threatening but requires prompt evaluation.

INDIVIDUAL EFFECTIVE DATE is the date stated on the Subscriber Enrollment Application, except that the Individual Effective Date for any other Covered Person is the date that the Covered Person became eligible as an Eligible Dependent of the Subscriber, but only if an Enrollment Application listing the Eligible Dependent is submitted to the Plan within thirty (30) days of eligibility, and the appropriate Rate is paid commencing with said date. A newborn child or an adopted child of a Subscriber or a Subscriber's eligible spouse is automatically Covered for the first thirty (30) days. Subscribers with full family Coverage currently in effect may enroll newborn dependents after the thirty (30) day period from date of birth.

INHERITED METABOLIC DISEASE means a disease caused by inborn errors of amino acid, organic acid or urea cycle metabolism and is treatable by the dietary restriction of one (1) or more amino acids.

INITIAL ELIGIBILITY PERIOD is the period of time, determined by the Group, during which Eligible Persons may enroll themselves and Eligible Dependents under the Group Service Agreement.

INPATIENT HOSPITAL SERVICES means the Medically Necessary services and supplies furnished to a Member who has been admitted to a Hospital for purposes of receiving Inpatient Hospital Services. Typical Inpatient Hospital Services include bed and board (room and board), nursing services, use of Hospital facilities, drugs, Biologic Products and Biopharmaceutical Drugs, supplies, appliances and equipment, and any other diagnostic or therapeutic items or services ordinarily furnished to inpatients.

LIFETIME MAXIMUM means that effective January 1st, 2003 and later, the maximum dollar amount the Plan will pay for Covered Services during the Covered Person's lifetime.

MAXIMUM OUT-OF-POCKET means the maximum amount that the Covered Person has to spend, per Covered Person per Calendar Year subject to the aggregate family Maximum Out-of-Pocket.

MEDICAL DEDUCTIBLE means the dollar amount of Covered Services listed in Article IV Schedule of Benefits for which the Covered Person is responsible before the Plan starts to pay for Covered Services subject to the Medical Deductible.

MEDICAL FOODS mean food products which are formulated to be consumed or administered enterally under the supervision of a physician and which are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Medical foods are not categorized by the Food and Drug Administration (FDA) as prescription drugs. Although these products may require physician supervision and may be labeled "Rx Only" for the purpose of assuring supervision, they do not require a prescription by law.

MEDICAL NECESSITY or **MEDICALLY NECESSARY** means services and/or supplies provided by a Hospital, Physician, or other Health Care Services provider to identify and treat an illness or injury that are:

1. consistent with symptoms, or diagnosis and treatment of the condition, disease, ailment or injury;
2. appropriate with regard to standards of good medical practice; and
3. not primarily for the convenience of the patient, the patient's family, the Physician or the Provider and
4. not more costly than an alternative service or place of service reasonably expected to produce equivalent therapeutic or diagnostic results.

MEMBERSHIP CARD means the document of identification issued by the Plan.

NETWORK is a defined group of Participating Providers, linked through contractual arrangements to each Network, which supply a full range of Health Care Services. The Network contracts with the Plan to provide services to Covered Persons who have selected the Network for the provision and coordination of all Health Care Services Covered under the Group Service Agreement. A Network does not include all of the Plan's Participating Providers.

1. In-Network means the Covered Person receives Health Care Services from his/her specific Network's Participating Providers, such as Primary Care Physicians, Specialty Physicians, Hospital(s), laboratories or Urgent Care Centers.
2. Out-of-Network means the Covered Person utilizes a provider or facility that is not contracted with his/her Network. For Urgent and Emergency Services, please see Article IV, Schedule of Benefits.

OBSERVATION STAY are those services furnished on a Hospital's premises, including use of a bed and periodic monitoring by a Hospital's nursing or other staff to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital as an inpatient as ordered by a Physician or other individual authorized by state licensure law and Hospital bylaws.

OPEN ENROLLMENT PERIOD means the period of time established by the Group, during which Eligible Persons who have not previously enrolled with the Plan may do so and during which Subscribers can make eligible changes.

ORTHOTIC means a device defined as a rigid or semi-rigid, fabricated, reusable, external and removable an orthopedic appliance or brace that is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

OUTPATIENT SERVICES means those institutional services rendered to a Covered Person who is not a bed patient in a Hospital or Skilled Nursing Facility at the time services are rendered.

OUTPATIENT SURGICAL CENTER means a licensed freestanding or Hospital-based medical facility that specializes in outpatient or same-day surgical procedures.

PARTICIPATING PHYSICIAN means a Participating Provider (Physician) who has entered into an agreement with the Plan or with another organization that has an agreement with the Plan to render services to Covered Persons under this Agreement. A directory of Participating Physicians available under this Agreement will be published from time to time by the Plan for use by Subscribers.

PARTICIPATING PROVIDER means a Physician, Specialty Physician, Hospital, laboratories, Health Care Services provider or other institution or service independent of the Plan who/which has entered into an agreement with the Plan or with another organization, which has an agreement with the Plan to render services to Covered Persons under this Agreement.

PHARMACY SERVICES:

When Pharmacy Coverage is selected by the Employer Group, Pharmacy Definitions pertain to Diabetic Drugs and Supplies, Family Planning Drugs, and Prescription Drugs in Article IV, Schedule of Benefits.

1. **Pharmacy Program** means the Plan program that establishes, updates and maintains the Plan's Pharmacy benefit. This program includes the programs, policies, medication lists, procedures and guidelines of the Pharmacy and Therapeutics Committee. The Pharmacy Program is mailed to the Member with their Membership Card and available on-line at www.mplan.com.
2. **Pharmacy & Therapeutics Committee** means the selected group of Plan Physicians from the various Networks, the Plan Medical Director, Plan Pharmacy Director and Plan Clinical Pharmacists that meet to review and update the Plan's Pharmacy Program.
3. **Pharmacy** means any facility, department or other place that has been issued appropriate state and/or federal licenses where prescriptions are filled or compounded and are sold, dispensed, offered or displayed for sale and which has as its principal purpose the dispensing of drugs and health supplies intended for the general health, welfare and safety of the public, without placing any other activity on a more important level than the practice of Pharmacy.
4. **Participating Pharmacy** means a Pharmacy independent of the Plan, which has entered into an agreement with the Plan, or with another organization that has an agreement with the Plan to render services to Covered Persons under this Agreement.

5. **Convenience Packaging** means any prescription drug product whose formulation or packaging offers no medical benefit and/or Medical Necessity over the product(s) containing the same prescription component(s) already available to Members in other formulations or packaging. A determination of Convenience Packaging is made by the Pharmacy and Therapeutics Committee
6. **Diabetic Drugs and Supplies** means the prescription drugs or supplies necessary for the treatment of Diabetes, such as insulin or test strips.
7. **Over-the-Counter (OTC) Drugs** mean those drugs that do not require a prescription in the United States and do not carry the Federal Legend (*Rx Only*) on their label.
8. **Over-the-Counter (OTC) Select Drugs** mean those OTC drugs which offer additional value over comparable OTC drugs as determined by the Pharmacy and Therapeutics Committee.
9. **Generic Drugs or Generic Equivalent Drug** means those prescription drugs whose brand name counterparts are no longer under patent protection. Generic Drugs must contain the same active ingredients as their brand name counterparts and must be identical in strength, dosage form and route of administration. Generic Drugs must also supply the same amount of the active ingredient in the body, at the same rate, as the brand name drug. Generic Drugs can be marketed only after the product and its manufacturer has been approved by the Food and Drug Administration (FDA). This requires that Generic Drugs be produced in accordance with stringent government regulations called current Good Manufacturing Practices (GMP).
10. **Generic Select Drugs** mean those Generic Drugs that are no longer Generic Non-Select and have a Plan or Health Care Finance Administration (HCFA) Maximum Allowable Cost (MAC) price set. Generic Drugs can be so placed by the Pharmacy and Therapeutics Committee.
11. **Generic Non-Select Drugs** mean those newly available Generic prescription Drugs that are Non-Select for a duration of six (6) months (or longer) until the time that the Generic Drug is developed by three (3) different manufacturers and the HCFA MAC or Plan MAC price is set. The Pharmacy and Therapeutics Committee may choose to keep a Generic Drug at the Generic Non-Select tier. The separation of Generic Drugs into Generic Select and Generic Non-Select Drugs is not applicable to all Employer Groups.
12. **Brand Select Drugs** mean those brand name prescription drugs mean those brand name prescription drugs that have no generic equivalent and offer additional value than comparable brand name drugs.
13. **Brand Non-Select Drugs** mean those prescription brand name drugs which the Plan has not included on its Brand Select list or have been so placed by the Pharmacy and Therapeutics Committee.
14. **State Restricted Drugs** mean non-federal legend drugs that are restricted to prescription order by state law.

PHYSICIAN means a practitioner of the healing arts holding an unlimited license in the State of Indiana for the practice of medicine or osteopathy, operating within the scope of his or her license as authorized by Indiana State Law.

PHYSICIAN SERVICES are professional or medical services rendered by a Physician when reasonable and Medically Necessary for the diagnosis or treatment of a condition, disease or ailment.

PLAN means M•Plan, Inc.

PREVENTIVE MEDICAL SERVICES means those outpatient Health Care Services provided by Participating Providers concerned with the prevention or detection of disease in a susceptible or potentially susceptible population. Preventive Medical Services include:

1. Specific protective interventions, such as vaccinations; and
2. Test/examinations for the early diagnosis of disease to shorten the duration and severity of illness, such as mammograms

PRIMARY CARE PHYSICIAN (PCP) means a Participating Physician who has agreed to assume primary responsibility for the medical care of a Subscriber or Eligible Dependent under the Plan (e.g. family practitioner, general practitioner, pediatrician, internist or obstetrician for maternity care).

PRIOR AUTHORIZATION or PRIOR AUTHORIZED means the process of obtaining Coverage approval by the Plan before receiving a service or medication except in an Emergency.

PROSTHETIC means a device defined as a fabricated, reusable, external, removable substitute for a diseased or missing part of the body.

PROVIDER means a Physician, Specialty Physician, Hospital, laboratories, Health Care Services Provider or other institution or operating within the scope of their license as authorized by state law.

RATE means the amount currently charged by the Plan for all benefits and services Covered under the Agreement.

RECONSTRUCTIVE SURGERY is performed on abnormal structures of the body caused by birth defects, developmental abnormalities, trauma, infection, tumors or disease.

REFERRAL PHYSICIAN means a Participating Physician who has entered into an agreement with the Plan or with another organization that has an agreement with the Plan, or has been approved by the Plan to render services to Covered Persons under this Agreement.

REASONABLE AND CUSTOMARY CHARGE means the maximum amount that the Plan determines is reasonable for Covered Services you receive, up to but not to exceed charges actually billed. Our determination considers:

1. Amounts charged by other Providers for the same or similar service;
2. Any unusual medical circumstances requiring additional time, skill or experience; and/or
3. Other factors the Plan determines are relevant, including but not limited to, a resource based relative value scale.

For a Network Provider, the Reasonable and Customary is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under participation agreement, the lesser amount will be the maximum Reasonable Charge.

RESPITE CARE means short-term inpatient or outpatient care to give a caregiver relief from the physical demand and emotional stress of caring for the hospice patient. Inpatient Respite Care means a short-term admission to a participating Hospital, hospice facility or nursing home to give a caregiver relief from the physical demands and emotional stress of caring for the patient. Outpatient Respite Care means outpatient care to give caregiver relief from the physical demands and emotional stress of caring for the patient.

RIDER is additional medical Coverage purchased by the Group in addition to basic Health Care Services Covered under the Group Service Agreement. Health Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when approved by the Plan.

SEMI-PRIVATE ACCOMMODATIONS is a room with two (2) or more beds. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary or when Semi-private Accommodations are not available.

SERVICE AREA means the Indiana counties in which the Plan is authorized by the Indiana Department of Insurance to conduct business.

SKILLED NURSING FACILITY means an institution or a distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care and has one or more Physicians and one or more registered professional nurses responsible for the care of said patient; has a requirement that every patient must be under the supervision of a Physician; maintains clinical records on all patients; provides twenty-four (24) hours nursing services; provides appropriate methods and procedures for the dispensing and administration of drugs and Biologic Products and Biopharmaceutical Drugs, and is duly licensed by the appropriate governmental authorities, if any, except the term "Skilled Nursing Facility" does not include any institutions or portions of any institutions which are exclusively for custodial or domiciliary care or for the care and treatment of mental diseases.

SPECIALTY PHYSICIAN means a Participating Physician who is not a Primary Care Physician who has entered into an agreement with the Plan or with another organization who has an agreement with the Plan, or has been approved by the Plan to render services to Covered Persons under this Agreement.

STABILIZED means to provide medical treatment to an individual in an Emergency as may be necessary to assure, with reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

1. The discharge of the individual from an Emergency department or other care setting where Emergency Services are provided to the individual.
2. The transfer of the individual from an Emergency department or other care setting where Emergency Services are provided to the individual to another health care facility.
3. The transfer of the individual from a Hospital Emergency department or other Hospital care setting where Emergency Services are provided to the individual to the Hospital's inpatient setting.

SUBSCRIBER means the Eligible Person, as defined as a **COVERED PERSON** or **MEMBER** excluding Eligible Dependents and/or a surviving spouse, who has applied for Enrollment in the Plan to receive medical services.

SURGICAL SERVICES means the performance of surgical procedures by a health professional that may be legally rendered by such person.

TREATMENT PLAN means the projected series of medical, surgical, dental and/or psychiatric interventions in the management of a Member, based on the individualized evaluation of what is needed to restore or improve the health and function of the Member. A Treatment Plan specifically identifies those procedures used for the cure or amelioration of a disease or pathological condition. A Treatment Plan outlines goals and timelines that serve as a reference for a Physician or treating Provider to monitor outcomes.

A Treatment Plan must include:

1. a diagnosis;
2. proposed treatment by type(s);
3. duration of treatment intervention(s);
4. who will be providing the treatment service(s);
5. the anticipated outcomes stated as goals;
6. The frequency by which the treatment plan will be updated; and
7. The treating Physician's or practitioner's signature.

URGENT CARE/IMMEDIATE CARE SERVICES means medical care for an unforeseen illness or injury that is not life threatening but requires prompt evaluation.

ARTICLE II - GROUP EFFECTIVE DATE, PAYMENT OF RATES, TERMINATION OF AGREEMENT

- A. A Membership Card will be issued to the Subscriber and spouse (if eligible) and each Eligible Dependent with pertinent information concerning the Member's coverage, expiration date and identification number. This card must be used to indicate coverage under the Plan. The Membership Card is the property of M•Plan, Inc. The Covered Person is responsible for any charges incurred after a Covered Person is terminated.
- B. Notwithstanding anything in this Article II to the contrary, the Plan shall continue to provide the benefits and services of the Agreement to the Subscribers and Covered Persons during the grace period, and the Group shall be liable for payment of Rates for such Subscribers and Covered Persons during such period.
- C. In the event of termination of this Agreement by the Group or the Plan, all entitlement to benefits for all persons covered hereunder as Covered Persons shall terminate as of the effective date of termination of this Agreement and this Agreement shall be of no further force or effect.

**ARTICLE III - ENROLLMENT, INDIVIDUAL EFFECTIVE DATE, TERMINATION OF
COVERAGE, CONTINUATION OF COVERAGE**

- A. All Eligible Persons desiring to enroll in the Plan are required to complete and sign a Subscriber Enrollment Application unless an alternative method of enrollment is agreed to by the Plan and the Group.
1. Each Eligible Persons must maintain a permanent residence within the approved Service Area. Each Eligible Person must select a Network of Participating Providers and within that Network, designate a Primary Care Physician whose office is located within fifty (50) miles of where the Eligible Person lives.
 2. And further, for each Covered Person, designate a Primary Care Physician within the Eligible Person's Network. Please see Article I, Definitions for Network.
 3. The Primary Care Physician will coordinate, supervise and provide ongoing medical care to the Covered Person with the Network's participating specialists and Hospitals. (See also Article III, Section H.)
 4. An Eligible Person and/or their Eligible Dependents may change Primary Care Physicians within the same Network every ninety (90) days, but no more frequently than twice yearly.
 5. An Eligible Person may change Networks only during an Open Enrollment period except when the Eligible Person moves more than fifty (50) miles from their PCP.
 6. If an Eligible Person commits Fraud as defined in Article I – Definitions, Coverage will be terminated retroactive to the date of the Fraudulent Act.
- B. If a Subscriber changes Coverage under this Agreement from Subscriber only to Subscriber and Eligible Dependent(s) Coverage due to the new addition of the Eligible Dependent(s) as defined in Article I, Covered Person and Eligible Dependents, hereof, such Eligible Dependent(s) Coverage shall commence on the date of the addition of the Eligible Dependent(s), if such request and payment of the appropriate Rate are received within thirty (30) days following such addition.
- C. Eligible Persons whose Enrollment Applications are received by the Plan shall have their Coverage hereunder become effective at twelve (12) midnight coincident with the date of eligibility established by the Group and approved by the Plan for health Coverage.
- D. No Covered Person shall have his/her coverage terminated under this provision because of the amount, variety or cost of the services required by such Covered Person. The coverage of any Covered Person shall terminate:
1. As provided in Agreement for Prepaid Health Care and Administrative Services.
 2. At twelve (12) midnight the last day a Covered Person qualified as a Covered Person as a result of termination of coverage by the Plan with notice for just cause including but not limited to: submission of fraudulent claims, refusal to follow a Plan Physician's treatment plan (subject to Grievance Procedure ruling if Covered Person requests), gross or repeated misbehavior including but not limited to abusive behavior towards health Providers or administrative staff in applying for or seeking any benefits under this contract, failure to pay any required copayments or deductible amounts which are the responsibility of the enrollee and the misuse of any Member materials as set forth in Article X, Section E of this Agreement.

No Covered Person shall be disenrolled under the provisions of Article III, D, 2, unless prior thereto he/she has been given written notice thirty (30) days in advance of this disenrollment. Such notice shall specify the reason or reasons for disenrollment and shall inform the Covered Person of his/her right to appeal the disenrollment.

E. Continuation of Coverage For Inpatients Upon Contract Termination By the Plan

If the contract is terminated by the Plan, a Member who is hospitalized for a medical or surgical condition on the date of termination will have continuation of Coverage for inpatient services for up to sixty (60) days. The continuation of Coverage is not required if one of the following occurs:

1. The Member is discharged from the Hospital;
2. Sixty (60) days pass after contract termination;
3. The hospitalized Member obtains from another carrier Coverage that includes the Coverage provided by the Plan;
4. The Group terminates the contract; or
5. The Plan terminates the Member's Coverage due to:
 - a. The Member knowingly provides false information to the Plan;
 - b. The Member's failure to comply with the rules of the Plan as stated in the contract;
 - c. The Member's failure to pay a premium within the grace period permitted under the Group Service Agreement.

F. Continuation of Coverage

1. If an eligible employee who has been continuously Covered under a health insurance plan for at least ninety (90) days:
 - a. loses Coverage under the Plan as the result of:
 - ii. termination of employment, except for an individual who was discharged because the individual committed a felony or theft in connection with the individual's work and was either convicted in a court of law or admitted to the theft;
 - iii. reduction of hours;
 - iv. marriage dissolution; or
 - v. attainment of any age specified in the Plan; and
 - b. requests a conversion policy from the small group employer insurer that insured the health insurance plan;
the individual is entitled to receive a conversion policy from the small employer insurer.
2. A request must be made within thirty (30) days after the individual loses Coverage under the health insurance plan.
3. The premium for a conversion policy issued shall not exceed one hundred and fifty (150) percent of the rate that would have been charged under the small employer health insurance plan with respect to the individual had been Covered as an eligible employee under the Plan during the same period. If the Plan under which the employee was Covered is canceled or is not renewed, the Rates shall be based on the rate that would have been charged with respect to the individual if the Plan had continued in force, as determined by the small employer insurer in accordance with standard principles.

If the benefit limits of the conversion policy are not more than the benefit limits of the small employer's health insurance plan, the small employer insurer shall credit the individual with any waiting period, deductible or coinsurance credited to the individual then the small employer's health insurance plan.

G. Special Enrollment of Eligible Individuals/Coverage Limitations for Members Who Reside Outside the Service Area

Eligible employees or the Eligible Dependents of eligible employees who lose other health care Coverage are permitted to enroll in the Plan if the Eligible Person requested Enrollment in the Plan within thirty (30) days of the loss of their Coverage, and if each of the following conditions are met:

1. The employee or Eligible Dependent was already Covered under other health care Coverage when the Plan was previously offered;
2. The employee or Eligible Dependent declined Coverage in the Plan because the employee had another source of Coverage;
3. The employee or Eligible Dependent exhausted his or her COBRA continuation Coverage or the individual's Coverage terminated because of a loss of eligibility for Coverage (due to legal separation, divorce, death, termination of employment or reduction in hours of employment) or termination of employer contributions towards Coverage.

An adopted child of a Subscriber or a Subscriber's eligible spouse is automatically Covered for the first thirty (30) days from the earlier of:

1. The date of placement for the purpose of adoption; or
2. The date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption and continues for thirty (30) days unless the placement is disrupted prior to legal adoption and the child is removed from placement.

For Coverage beyond the first thirty (30) days, an Enrollment Application must be filed with the Plan and applicable premiums paid within the thirty (30) day period described above.

A child born to a Subscriber or a Subscriber's eligible spouse is automatically Covered for the first thirty (30) days from date of birth. For Coverage beyond the first thirty (30) days, an Enrollment Application must be filed with the Plan and applicable premiums paid within the first thirty (30) days from the date of birth. Subscribers with full family Coverage currently in effect may enroll newborn dependents after the thirty (30) day period from date of birth.

If an Eligible Dependent child is:

1. incapable of self-sustaining employment by reason of being mentally or physically disabled; and
2. chiefly dependent upon the Subscriber for support and maintenance at the time he or she reaches the specified age, then such Eligible Dependent child shall remain an Eligible Dependent child for the duration of such disability and dependency; or
3. a Dependent child of the Subscriber or spouse who attained the limiting age while Covered under another health care policy meets the criteria specified above, said Dependent child is an Eligible Dependent for enrollment. Proof of disability as described below will be required.

The Plan may require proof of the person's disability and/or dependency be furnished to the Plan by the Subscriber within one-hundred twenty (120) days of the child's attainment of the limiting age and subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The Plan may require proof once per year in the time more than two (2) years after the child's attainment of the limiting age.

An eligible employee who a court has ordered through a qualified support order that health Coverage be provided for a spouse or a minor or Eligible Dependent child of an eligible employee may enroll these Eligible Dependents in the Plan outside of open enrollment.

An Eligible Person must select a Primary Care Physician for each Covered Eligible Dependent within the Eligible Person's Network of Participating Providers. The Primary Care Physician will coordinate, supervise and provide ongoing medical care to Covered Persons with the Network's participating specialists and Hospitals.

Eligible Dependents or COBRA eligibles who reside more than fifty (50) miles from the Primary Care Physician's office designated within the Network of Participating Providers selected by the Eligible Person have Coverage only for Urgent or Emergent Care and must utilize their Network's Participating Providers for all other Health Care Services.

H. Family and Medical Leaves of Absence

A Covered Person who is on an approved leave under the Family and Medical Leave Act of 1993 (FMLA), as it may be amended from time to time, may continue participation in the Plan commensurate with the type of Coverage in effect on the day immediately before the leave begins by continuing to pay the required employee contribution.

FMLA continuation of Coverage will continue until the first of the following to occur:

1. The employee's return to active employment with the employer; or
2. The end of the twelve (12) week FMLA leave period. In the event a Member does not return to active employment at the end of the twelve (12) week FMLA leave period, Coverage under the Plan may be continued under COBRA, with the COBRA period measured from the date FMLA leave ends.

I. Military Service Leaves of Absence

If a Member is absent from work due to military service, the employee may elect to continue participation in the Plan commensurate with the type of Coverage in effect on the day immediately prior to the start of leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as it may be amended from time to time. Coverage will continue until the earlier to occur (a) the date the employee fails to return to active employment as required under USERRA, or (b) eighteen (18) months. In order to continue Coverage, the employee must continue to pay the required contribution under the Plan during the first thirty (30) days of leave. Thereafter, the employee is required to pay a premium in the same amount as that required under COBRA.

J. Certification of Creditable Coverage

Plan shall provide each Eligible Person, Eligible Dependent or COBRA beneficiary who is a Plan participant with a written statement showing the period of Coverage as a Plan participant at each of the following times:

1. When the participant ceases to be a Covered Person.
2. When the participant ceases to be an Eligible Person or Eligible Dependent.
3. Upon a COBRA beneficiary's cessation of COBRA Coverage; and
4. Upon request by a former Plan participant at any time within two (2) years after the later of the date such person ceases to be a Covered Person or the date such person ceases to be a COBRA beneficiary.

ARTICLE IV - SCHEDULE OF BENEFITS

Unless otherwise specifically stated to the contrary, the benefits and services described are Covered services only if and to the extent that the services are:

1. Medically Necessary, and
2. Prescribed, provided or referred by the Member's Primary Care Physician , and
3. Prior Authorized in accordance with the Plan's policies and procedures.

Any medical service, prescription drug, medicine, equipment, supply or procedure directly or indirectly related to a service which is not Medically Necessary, or is not consistent with Treatment Plan for Pervasive Developmental Disorders, or services, recommended by a Participating Physician, that are not services Covered by the Plan or not required in accordance with accepted standards of medical practice are not Covered in part or in full.

Although many services are directed by the Member's Primary Care Physician, the Member shares in the responsibility to be aware of receiving care from Participating Providers. If the Member has been referred to a Specialty Physician, the Member should call to verify that the referral has been received prior to the scheduled appointment. Referrals from the Member's Specialty Physician to another Specialty Physician must be made with Prior Authorization of the Member's Primary Care Physician. Membership Cards should be presented at all appointments.

Covered services are available only from Participating Providers unless:

1. Prior Authorized by the Medical Director of the Plan or his designee, or
2. Such services are Emergency Services or Urgent Care Services when the Covered Person is beyond a fifty (50) mile radius of his/her Primary Care Physician's office.

Neither the Plan nor its Participating Providers have any liability or obligation for any service or benefit sought or received by any Member from any other Physician, Hospital or other person, institution or organization.

Participating Providers are not authorized to speak on behalf of the Plan as to what is a Covered service. Therefore, actions or statements by Participating Providers, which are inconsistent with these requirements, will not be considered a waiver of these requirements. Failure to obtain Prior Authorization from the Member's Medical Network or a Medical Director of the Plan when Prior Authorization is required will result in denial of Coverage.

Some Covered services may require Copayments or Coinsurance to be made by the Member to the provider of services.

Medical Deductible as defined in Article I, Definitions:

The Calendar Year Medical Deductible for any one Covered Person is five hundred dollars **(\$500)**. The aggregate family Calendar Year Medical Deductible is five hundred dollars **(\$500)**. The Medical Deductible will be waived for:

1. Subscribers who are Non-Tobacco Users and are enrolled in Single coverage, or
2. The family members of Subscribers who are Non-Tobacco Users when the Subscriber has enrolled in Family coverage.

The Medical Deductible is met when:

1. any one Covered Person has accumulated more than five hundred dollars (**\$500**) for Covered Health Care Services in a Calendar Year; or
2. the family, in aggregate, has accumulated more than one five hundred dollars (**\$500**) in Covered Health Care Services in a Calendar Year.

The Plan provides Covered Health Care Services in the following ways. All covered services are subject to the deductible with the exception of those listed below.

1. Covered Health Care Services that require a **Copayment**: The Member does not have to meet their Medical Deductible before the following Covered Health Care Services with Copayments are available at the Copayment dollar amount listed in Article IV, Schedule of Benefits. These Copayments do not accumulate towards the Medical Deductible.
 - a. Professional services for Physician Office Visits. These professional services include physical check-ups and examinations; well-child care and routine pediatric visits; immunizations and injections; and Type I Preventive Medical Services.
 - b. Preventive Medical Services – Type I, including mammogram screenings, PAP screenings, PSA screenings and fecal occult blood tests (FOBT)
 - c. Office Visits for Mental Health or Chemical Dependency/Substance Abuse Services
 - d. Diabetic Drugs and Supplies (Outpatient)
 - e. Pharmacy Services
 - f. Nutrition for Inherited Metabolic Disease
 - g. Vision Exams
2. Covered Health Care Services that require **Coinsurance**: Before Covered Health Care Services would be eligible for Coverage at the Coinsurance percentage listed in Article IV, Schedule of Benefits, the Member, or their family, must first meet their Calendar Year Medical Deductible. Until the Medical Deductible is met, the Member is responsible for the cost of Covered Health Care Services.

The following Health Care Services, otherwise subject to Coinsurance, are not subject to a Calendar Year Medical Deductible. The Plan will Cover these Health Care Services at the applicable Coinsurance before the Member satisfies their Medical Deductible. Any Coinsurance applied to these services does not accrue to the Member's individual or family Medical Deductible.

- a. Prescription Drugs Pharmacy Services including the following:
 - i. Diabetic Drugs and Supplies (Outpatient)
 - ii. Nutrition for Inherited Metabolic Disease
 - iii. Prescription Drugs
 - iv. Biopharmaceutical Drugs/Injectable Drugs

Deductible Carry-Over Provision – If an individual or family has not accumulated enough expenses to meet their Calendar Year Medical Deductible, expenses incurred as a Member of this Plan during the last three (3) months of the Calendar Year, (October, November and December) will be applied or carried-over to the next Calendar Year.

Maximum Out-of-Pocket (Medical) as defined in Article I, Definitions:

The Calendar Maximum Out-of-Pocket for any one Covered Person is two thousand dollars (**\$2,000**).
The family Calendar Year Maximum Out-of-Pocket is four thousand dollars (**\$4,000**).

Once the Maximum Out-of-Pocket amount is reached, the Plan will pay one hundred (100%) percent for most additional Health Care expenses for the rest of the Calendar Year. Until the Maximum Out-of-Pocket amount is reached, the Member is responsible for the applicable Coinsurance required for eligible Covered Health Care Services. The Maximum Out-of-Pocket does not include the Medical Deductible.

The Maximum Out-of-Pocket is met when:

1. any one Covered Person has accumulated more than two thousand dollars **(\$2,000)** for eligible Covered Health Care Services in a Calendar Year; or
2. the family, in aggregate, has accumulated more than four thousand dollars **(\$4,000)** for eligible Covered Health Care Services in a Calendar Year, limited to a maximum of two thousand dollars **(\$2,000)** dollars contributed by any one Covered Person.

Coinsurance for the following Covered Health Care Services do not apply to the individual or family Maximum Out-of-Pocket identified above. The Member will continue to be responsible for the applicable Coinsurance required for these eligible Covered Health Care Services.

1. Pharmacy Services including:
 - a. Diabetic Drugs and Supplies (Outpatient)
 - b. Nutrition for Inherited Metabolic Disease
 - c. Prescription Drugs
 - d. Biopharmaceutical Drugs/Injectable Drugs

Copayments for the following Covered Health Care Services do not apply to the individual or family Maximum Out-of-Pocket identified above. The Member will continue to be responsible for the applicable Copayments required for these eligible Covered Health Care Services.

1. Diabetic Drugs and Supplies (Outpatient)
2. Pharmacy Services, including Biopharmaceutical Drugs/Injectable Drugs
3. Nutrition for Inherited Metabolic Disease

The Lifetime Maximum for this Group Service Agreement is one million dollars (\$1,000,000) per Covered Person (excluding Transplant Services - There is a separate lifetime maximum for Transplant Services).

The Transplant Lifetime Maximum for this Group Service Agreement is one million dollars (\$1,000,000) per Covered Person. The Lifetime Maximum for Transplant Services does not accumulate towards the Lifetime Maximum for this Group Service Agreement. Pharmacy Services do not accumulate to the Transplant Maximum.

Covered Services

Please reference Article I, Definitions and Article V, General Exclusions and Limitations, for exclusions *in addition* to those listed with the benefits in this Article.

Ambulance Service

Copayment/Coinsurance Required

\$50 per transport

Ambulance services to a Hospital when requested by a Participating Physician are Covered. A Participating Physician's prescription or referral is not required if ambulance services are used in an emergency situation. The Member's Medical Network or the Plan will review all non-authorized ambulance services to determine the Medical Necessity for ambulance services. (Unnecessary or unauthorized ambulance service is not a Covered benefit). Air ambulance services require the Plan's Prior Authorization unless rendered in an emergency. Only ground transportation ambulance services will be approved unless air ambulance services are required for Member safety.

Exclusions

1. Non-emergency ambulance services or ambulance services not authorized by a Primary Care Physician or the Plan's Medical Director.
2. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Biopharmaceutical Drugs/Injectable Drugs

Copayment/Coinsurance Required

Outpatient: 20% of Eligible Expenses

Inpatient: No Charge

To be Covered, a Biopharmaceutical Drug must be

1. Medically Necessary, and
2. The Food & Drug Administration (FDA) approved for the particular condition being treated. If the Biopharmaceutical Drug has not been approved by FDA for the particular indication being treated, it is Covered:
 - a. According to the Plan's benefit interpretation guidelines and limitations if applicable, or
 - b. The Biopharmaceutical Drug is recognized for the treatment of a particular condition/type of cancer in at least one of the following standard reference compendiums: The United States Pharmacopeia Drug Information (Evidence I only will be accepted), or the American Hospital Formulary Service Drug Information (from standard of care discussion as indicated by a ψ and not experimental discussion) or,
 - c. The Biopharmaceutical Drug is demonstrated for a particular condition/type of cancer to be safe and effective in at least two (2) formal clinical studies, the results of which have been published in peer reviewed professional medical journals published in the United States, Great Britain, Canada or Australia.
3. See Article IV, Hospital Services.

Exclusions

1. Biopharmaceutical Drugs not approved by the FDA or not indicated for the particular condition/type of cancer in at least one of the following standard reference compendiums: The United States Pharmacopeia Drug Information (Evidence I only will be accepted) or the American Hospital Formulary Service Drug Information (from standard of care discussion as indicated by a □ and not experimental discussion), except as stated above under “Covered”.
2. Allergy Serum/Extracts
3. Infertility Biotech Product drugs (See Article IV, Pharmacy Services - Family Planning Drugs)
4. Insulin (See Article IV, Pharmacy Services - Diabetic Drugs and Diabetic Supplies)
5. Immunizations, vaccinations or inoculations or allergy testing (See Article IV, Preventive Medical Services)
6. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Cardiac Rehabilitation Therapy**Copayment/Coinsurance Required**

Phase I – Inpatient	Subject to Hospital Inpatient Copayment/Coinsurance
Physician Services	Applicable Physician Services, Non-Office Visit Copayment will apply
Phase II – Outpatient	\$20 per visit
Physician Services	Applicable Physician Services, Non-Office Visit Copayment will apply

Cardiac rehabilitation is Covered when prescribed for a Member with coronary artery disease following a recent (within twelve (12) months) acute event such as acute myocardial infarction, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty, cardiac transplantation, cardiac valve surgery, cardiac stent placement, or one course of therapy following the initial diagnosis of congestive heart failure. Phase I/Inpatient Stay and Phase II/Outpatient Period cardiac rehabilitation services are Covered with the Phase II/Outpatient Period being limited to thirty-six (36) sessions over a twelve (12) week period.

Exclusions

Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

**Chemical Dependency and Substance Abuse
Services - Inpatient And Outpatient****Copayment/Coinsurance Required**

Inpatient and outpatient services when prescribed, directed or authorized by the Member’s Network Behavioral Health Intake and Triage Center or by the Member’s Primary Care Physician pursuant to an approved referral.

Inpatient -

Chemical Dependency/Substance Abuse
Hospital Services. Hospital Inpatient settings
provide continuous (24 hours per day) skilled
nursing care, daily medical care, therapeutic

activities and assessment, and inpatient Chemical Dependency/Substance Abuse rehabilitation services when approved by the Plan.

Subject to Hospital Inpatient Copayment/Coinsurance

Physician Services. Treatment by psychiatrists and other physicians in an inpatient setting

Applicable Physician Services, Non-Office Visit Copayment will apply

Outpatient -

- | | |
|--|-------------------|
| 1. Chemical Dependency and Substance Abuse Services – Office Visit | 1. \$20 per visit |
| 2. Other Outpatient Chemical Dependency and Substance Abuse Services – such as other Intensive Outpatient Program Services (each three (3) hour session equals one (1) outpatient visit), and partial hospitalization or day treatment (each visit equals one (1) outpatient visit). | 2. \$20 per visit |

Definitions

The continuum of care for Chemical Dependency and Substance Abuse rehabilitation services includes:

1. Inpatient Chemical Dependency and Substance Abuse Services use an inpatient treatment setting for individuals who require acute detoxification from Chemical Dependency and Substance Abuse disorders. These settings provide continuous (24 hours per day) skilled nursing care, daily medical care, the availability of psychiatrists, physicians qualified in addiction medicine, and physicians in other appropriate specialties 24 hours per day either on-call or in-house, and intensive multi-modal, multidisciplinary assessment and treatment.
2. Partial Chemical Dependency and Substance Abuse Hospitalization Services refer to an intensive, structured setting providing medically supervised diagnostic and therapeutic services. Partial hospital programs operate five to six hours per day, five days per week. During program hours, partial hospital programs provide services equivalent in intensity and scope to those provided in acute inpatient settings. Partial hospital programs provide skilled nursing care and the availability of daily psychiatric and addiction medicine care.
3. Intensive Chemical Dependency/Substance Abuse Outpatient Services refer to an intensive outpatient program that is a structured setting providing multidisciplinary diagnostic and therapeutic services. Intensive outpatient programs operate at least three hours per day, three days per week. Intensive outpatient programs need not be medically supervised, however, they must have a formal arrangement for psychiatric and/or addiction medicine consultation as needed.
4. Outpatient Chemical Dependency and Substance Abuse Services are traditional Outpatient Services that are typically provided in an office or clinic setting and consist of individual, group and family assessment, counseling or psychotherapy and/or individual medication management.

Limitations

Inpatient services for Chemical Dependency/Substance Abuse shall be limited to diagnosis, evaluation and treatment for acute detoxification

Exclusions

1. Experimental/medical psychiatric procedures, pharmacological regimens and associated Health Care Services, and/or those services or procedures that are not consistent with accepted standard medical practice, or services requiring approval by any governmental authority prior to use where such approval has not been granted or services not approved for Coverage by Medicare
2. Substance Abuse or Chemical Dependency therapy on court order or as a condition of parole, unless treatment otherwise would be Covered
3. Coverage for Custodial Care, nursing home care, Respite Care, rest cures and domiciliary care, regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including services in group homes, halfway houses or residential facilities
4. Mental Health Services (see Article IV, Mental Health Services)
5. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Dental Services - Emergency

Copayment/Coinsurance Required

Subject to applicable Copayment/Coinsurance

1. Emergency care required to relieve pain and stop bleeding as a result of accidental injury to sound natural teeth when provided within twenty-four (24) hours of the injury.
2. Re-implantation of natural teeth within twenty-four (24) hours of loss due to accidental injury.
3. Coverage for general anesthesia administered in a Hospital or Outpatient Surgical Center, please see Article IV, Hospital Services or Outpatient Surgical Services.

Exclusions

1. Injury resulting from mastication
2. Dental services, surgery, treatment or care, or dental x-rays, dentures and implants, supplies and associated expenses (including hospitalization, except for those services described above.)
3. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Diabetic Drugs and Diabetic Supplies (See Pharmacy Services)

Dialysis

Copayment/Coinsurance Required

Inpatient

Subject to applicable Hospital Inpatient
Coinsurance

Physician Services

Applicable Physician Services, Non-Office Visit
Copayment will apply

Outpatient

\$20 per treatment

Physician Services

Applicable Physician Services, Non-Office Visit
Copayment will apply

Services and supplies per the Plan's specifications for both acute and chronic dialysis. If Covered by Medicare, see Article IX, Section L.

Exclusions

Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Durable Medical Equipment

Copayment/Coinsurance Required

20% of Eligible Expenses

Durable Medical Equipment and related components are Covered when Medically Necessary and authorized in accordance with the Plan's Prior Authorization process and included on the Durable Medical Equipment list. Coverage will not exceed the minimal alternative that is Medically Necessary to allow the Member to meet their potential functional ability.

Exclusions

1. Convenience items as defined by the Plan
2. An option/accessory that is beneficial primarily in allowing the Member to perform leisure or recreational activity is not Covered
3. Repair or replacement of lost, neglected or stolen equipment
4. Duplicate equipment
5. Routine service that does not require the skill of a technician
6. Non-reusable items
7. Equipment and devices used for environmental control or to enhance the environmental setting in which the Member resides (e.g., air conditioners, air filters, heaters, humidifiers)
8. Equipment for use in exercising or training, including but not limited to, devices for home use ordered in conjunction with rehabilitation therapies (e.g., exercise putty, bands or balls)
9. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Emergency Room Services

Copayment/Coinsurance Required

Emergency Room Facility

\$75 per emergency room visit

Physician Services

Applicable Physician Services, Non-Office Visit
Copayment will apply

The applicable Emergency Room Services Copayment or Coinsurance will be waived in the event the visit results in the Member being admitted as a Hospital Inpatient at the same Hospital. Any applicable Inpatient Copayment will apply at that point; see Article IV, Hospital Services. Any applicable Copayment/Coinsurance will not be waived for an Observation Stay.

1. Emergency Services are Covered for care obtained in an emergency by a Covered Person without:
 - a. Prior Authorization; or
 - b. Regard to the contractual relationship between:
 - i. The Provider who provided Health Care Services to the Covered Person in an emergency; and
 - ii. The health organization;

In a situation where a prudent lay person could reasonably believe that the Covered Person's condition required immediate medical attention. The emergency care obtained by a Covered Person includes care for the alleviation of severe pain, which is a symptom of an emergency.

2. If Emergency Services are received from an Out-of-Network Provider, the Plan must be notified within forty-eight (48) hours of the start of such emergency care or as soon as reasonably possible thereafter. The Plan may, at its sole option, elect to transfer the patient at its expense to the care of a Participating Provider, subject to the condition that such transfer not jeopardize the Member's health.
3. All claims for Hospital Emergency Services and Out-of-Network Emergency Services will be retrospectively reviewed by the Plan to determine if a Medical Emergency existed. If it is determined that a Medical Emergency as described herein did not exist and the Member's Primary Care Physician did not refer the Member for emergency care, then the Member shall be liable for the entire cost of such services.
4. Continuing or follow-up care is not Covered Out-of-Network unless such care is authorized by the Plan's Medical Director.
5. Care and treatment provided to a Covered Person once the Covered Person is Stabilized is not care obtained in an emergency.

Exclusions

Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Family Planning - Procedures and Devices

Copayment/Coinsurance Required

- | | |
|---|--|
| 1. Sterilizations, pre and post -surgical consultations, including labs when approved in advance by the Member's Medical Network or the Plan}(Tubal Ligation, Vasectomy Essure™ and VasClip®) | 20% of Eligible Expenses |
| 2. Elective abortions | Not Covered |
| 3. Infertility – initial diagnostic testing and counseling | 20% of Eligible Expenses |
| 4. Contraceptive Devices | |
| Diaphragms and cervical caps | 20% of Eligible Expenses |
| Fitting of diaphragms and cervical caps | Applicable office visit Copayment or Coinsurance applies |
| IUDs - including insertion or removal | 20% of Eligible Expenses |

Definitions

Infertility is defined as the involuntary inability to conceive after twelve (12) months of unprotected intercourse.

Exclusions

1. Infertility drugs and the monitoring of drug therapy (See Article IV, Pharmacy Services - Family Planning Drugs)
2. Reversal of voluntary or induced sterilization procedures
3. Surrogate parenting procedures
4. Amniocentesis unless Medically Necessary
5. Sperm, egg or inseminated egg procurement, processing
6. Embryo, sperm or egg banking
7. Assisted reproductive technology (ART) services except for artificial insemination as determined to be Medically Necessary and approved by the Plan. ART including but not limited to in vitro fertilization and embryo placement (IVF-EP), gamete intrafallopian transfer (GIFT), intracytoplasmic sperm injection (ICSI) and zygote intrafallopian transfer (ZIFT).
8. HI/LA typing (human leukocyte antigen)
9. Hormone pulsating infusions
10. Animal egg penetration testing
11. Sperm antibody testing
12. Elective Abortions
13. Testing after diagnosis of infertility
14. Treatment and surgical procedures to correct infertility
15. Artificial insemination cycles
16. Please reference Article IV, Outpatient Services for Copayment/Coinsurance information.
17. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Hearing Aids and Related Services

Not Covered

Genetic Counseling and Testing

Copayment/Coinsurance Required

Counseling

\$20 per visit

Testing

Subject to Outpatient Services-Laboratory, Pathology, and Radiology Services Copayment/Coinsurance

Coverage

Services are limited to:

1. genetic counseling and/or testing for chromosomal and/or genetic disorders (e.g., genetic carrier testing for cystic fibrosis) during the prenatal and neonatal period;
2. genetic counseling and/or testing for inheritable disorders for the purpose of family planning for at risk members;
3. genetic counseling and/or testing for the prevention, delayed onset, or cure of the disease (the Plan may request genetic counseling prior to approving genetic testing);
4. oncogene (cancer gene) testing with prior genetic counseling (by either a board certified or eligible genetic counselor indicated by CGC from the National Society of Genetic Counselors, Cancer Risk Counseling Special Interests Group) and prior approval of the Plan, for example BRCA1 and BRCA2 testing only after genetic counseling has been provided; and require Prior Authorization by the Plan.

Exclusions

1. Genetic counseling and testing for inheritable diseases for which there are no known effective treatments available.

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2. Oncogene (cancer gene) testing prior to genetic counseling (by either a board certified or eligible genetic counselor indicated by CGC from the National Society of Genetic Counselors, Cancer Risk Counseling Special Interests Group) and prior to authorization by the Member's Medical Network
3. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Home Health Care Services

Copayment/Coinsurance Required

\$20 per visit

1. Home Health Care Services and supplies provided by a skilled nurse and/or Home Health aide on an intermittent or part-time basis, in accordance with the treatment plan that is ordered and monitored by the Primary Care Physician. Intermittent shall mean less than eight (8) hours per day and less than twenty-eight (28) hours per week.
2. The services of a home health aide are covered when reasonable and necessary for the treatment of the Covered Person's illness or injury are included on the home health plan of care for skilled services.
3. Home Health Care Services solely for the purpose of rehabilitation therapy such as physical therapy, occupational therapy and speech therapy are subject to the visit limitations and Copayments applicable to those services as defined in Article IV, Rehabilitation Therapy.
4. Applicable Copayments/Coinsurance, dollar limits and deductibles will apply to Services, including but not limited to, Durable Medical Equipment, Orthotics and Prosthetics, Physician Services and Pharmacy Services. For applicable Copayment/Coinsurance, see section in this Article.

Exclusions

1. Home Health care solely for the purpose of Rehabilitation Therapy that exceeds Rehabilitation Therapy visit limits (See Article IV, Rehabilitation Therapy)
2. Personal comfort items
3. Diapers
4. Special diets at home, except for parenteral formulas or supplements such as hyperalimentation and restorative enteral feedings
5. Custodial Care or domiciliary care
6. Services, supplies, drugs or care that is provided, performed or ordered by an immediate family member (i.e., the Member, the Member's spouse or a child, brother, sister or parent of the Member's spouse) or Member of the household
7. Homemaker or housekeeping services
8. Private duty nursing unless determined to be Medically Necessary
9. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Hospice Care/Respite Care

Copayment/Coinsurance Required

Outpatient Hospice Care

No Charge

Physician Services

Applicable Physician Services, Non-Office Visit
Copayment will apply

Respite Care - Inpatient or Outpatient;
subject to Plan approval

No Charge

Physician Services

Applicable Physician Services, Non-Office Visit
Copayment will apply

Hospice Care services are Covered for Members when all the following criteria are met:

1. The medical diagnosis projects a life expectancy of six months or less if the disease follows its normal course;
2. The patient and family agree that symptom and pain management rather than curative treatment are the goals of care;
3. Orders from the Primary Care
4. Prior Authorization by the Member's Medical Network; and
5. A full-time caregiver in the home is available.

Exclusions

1. Inpatient custodial or domiciliary hospice program unless in lieu of acute hospitalization
2. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Hospital Services

Copayment/Coinsurance Required

Hospital Inpatient Services

\$500 per admission

Copayment/Coinsurance will apply to each newborn only if newborn stays beyond the mother's date of discharge or seven (7) days after date of birth.

Emergency Room Services

See Article IV, Emergency Services

Those Medically Necessary services and supplies generally performed and customarily provided by Hospitals only when prescribed, directed or authorized by a Member's Primary Care Physician or a Physician to whom the Member has been referred for care pursuant to an approved referral.

Except in an Emergency, Hospital Services must be prior authorized by the Plan. Covered Services received by the Member include:

1. Semi-private room and board. Private room only when Medically Necessary
2. General nursing care
3. Operating room and related facilities
4. Intensive care and cardiac care unit and related services
5. Anesthesia and oxygen service
6. Hospital ancillary services including laboratory, pathology, radiology, physical therapy, radiation therapy, and inhalation and respiratory therapy
7. Drugs, medications, Biologic Products and Biopharmaceutical Drugs as prescribed and intended for use while the Member is a registered bed patient
8. Blood and the administration of whole blood and blood plasma
9. Special diets
10. Coordinated discharge planning services
11. Rehabilitation therapy, which includes physical, occupational, speech and cardiac, of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning. For specific Coverage limitations see Article IV, Cardiac Rehabilitation Therapy or Article IV, Rehabilitation Therapy.

12. Anesthesia and Hospital charges for dental care for a child or a disabled Member whose mental or physical condition requires dental treatment to be rendered in a Hospital or ambulatory surgery center

Exclusions

1. Family Planning Services (See Article IV, Family Planning - Procedures and Devices)
2. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Mastectomy Services

Copayment/Coinsurance Required

Applicable Copayment/Coinsurance for the specific Health Care Service provided shall apply

Physician Services

Applicable Physician Services, Non-Office Visit Copayment will apply

Services, as mandated by State and Federal law, for the removal of all or part of the breast, including coverage for

1. Prostheses physical complications for all stages of mastectomy, including lymphedemas, and
2. Reconstructive Surgery incident to the mastectomy including:
 - a. All stages of reconstruction of the breast on which the mastectomy has been performed; and
 - b. Surgery and reconstruction of the other breast to produce symmetry;in the manner determined by the Member's Primary Care Physician or a Physician to whom the Member has been referred by the Primary Care Physician and the Covered Person to be appropriate.

Exclusions

Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Mental Health Services - Inpatient And Outpatient

Copayment/Coinsurance Required

Inpatient and outpatient services when prescribed, directed or authorized by the Member's Network Behavioral Health Intake and Triage Center or by the Member's Primary Care Physician pursuant to an approved referral.

As mandated by Indiana State Law, the following services for mental health must have similar treatment limitations or financial requirements as other medical conditions. The following services are not limited.

Inpatient -

Mental Health Services. Hospital Inpatient settings provide continuous (24 hours per day) skilled nursing care, daily medical care, therapeutic activities and assessment.

Subject to applicable Hospital Inpatient Copayment/Coinsurance

Outpatient -

1. Mental Health Services – Office Visit \$20 per visit
2. Other Outpatient Mental Health \$20 per visit
Services – such as:
 - a. electroconvulsive therapy (ECT)
 - b. other Intensive Outpatient Program
Services (each three (3) hour
session equals one (1) outpatient
visit)
 - c. partial hospitalization or day
treatment (each visit equals one (1)
outpatient visit)

Outpatient Mental Health Services are traditional Outpatient Services that are typically provided in an office or clinic setting and consist of individual, group and family assessment, counseling or psychotherapy and/or individual medication management.

Intensive Outpatient Program refers to an Intermediate Ambulatory mental health program. Planned hours of treatment are three to four hours per day, at least two to three days per week (Association for Ambulatory Behavioral Healthcare 1999).

Intermediate Ambulatory services are characterized by active treatment frequently with a rehabilitative or transitional function that incorporates into the treatment plan the benefits of stable, staff supported milieu that extends beyond the treatment setting into the significant parts of the patient's community network. Attendance at the program is more flexible and may not be needed on a full time basis as patients may function adequately in other structured settings, such as school or work. Milieu based intensive outpatient programs are a good example of Intermediate Ambulatory services (Association for Ambulatory Behavioral Healthcare 1999).

Exclusions

1. Long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities
2. Mental Health Services for gambling addictions and paraphilia (e.g., exhibitionism, voyeurism, sadism or pedophilia).
3. Services for the treatment of Chemical Dependency/Substance Abuse including diagnosis, evaluation and treatment of acute detoxification (See Article IV, Chemical Dependency and Substance Abuse)
4. Experimental psychiatric procedures, pharmacological regimen and associated Health Care Services or procedures not consistent with accepted standard medical practice
5. Behavioral training, approaches that use classical or operant conditioning and/or interventions that focus on skills training (Examples include, but are not limited to, functional analysis, assertiveness training, smoking cessation, stress management, progressive muscle relaxation)
6. Remedial education and testing to evaluate school performance and/or diagnose or treat learning disabilities
7. Psychiatric therapy on court order or as a condition of parole or probation unless treatment otherwise would be Covered

8. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Morbid Obesity Surgical Services

Copayment/Coinsurance Required

20% of Eligible Expenses, limited to one (1) per lifetime

Definitions

1. Morbid Obesity means (Indiana Code 27-8-14.1-4)
 - a. a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
 - b. a body mass index of at least forty (40) kilograms per meter squared without comorbidity.
2. Major Life Activities are (Indiana Code 4-23-29-6):
 - a. Self-care
 - b. Receptive and expressive language
 - c. Learning
 - d. Mobility
 - e. Self-direction
 - f. Capacity for independent living
 - g. Economic self-sufficiency

Coverage

Non-experimental weight-loss surgery for Morbid Obesity, as mandated by Indiana State Law, when:

1. Morbid Obesity, as defined above, has persisted for at least five (5) years; and
2. non-surgical treatment that meets the Plan's weight loss requirements, supervised by your Participating Physician for at least six (6) consecutive months, has been unsuccessful; and
3. services have been Prior Authorized by the Plan.

Limitations

Authorizations for Coverage of elective surgeries will not be made by the Plan more than three (3) months prior to the date of surgery.

Exclusions

1. Weight management programs such as, but not limited to Jenny Craig®, Optifast® and Weight Watchers®
2. Coverage for post weight loss cosmetic procedures
3. Surgical treatment of Morbid Obesity for a Member who is less than twenty-one (21) years of age unless two (2) Participating Physicians determine that the surgery is necessary to save the life of the Member; or restore the Member's ability to maintain a Major Life Activity. Each Physician must document in the Member's medical record the reason for the Physician's determination (IC 27-13-6-14.5)
4. Please reference Article IV, Pharmacy Services, for specific drug coverage.
5. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Nutrition for Inherited Metabolic Disease**Copayment/Coinsurance Required**

Generic formulas	\$10
Brand Select formulas	\$20
Brand Non-Select formulas	40% of Eligible Expenses (\$40 minimum, \$100 maximum)

Coverage

1. The nutrition for an Inherited Metabolic Disease, as mandated by Indiana State Law, means a formula that is:
 - a. intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
 - b. formulated to be consumed or administered enterally under the direction of the Covered Person's Participating Physician; and
 - c. prescribed by a Covered Person's Participating Physician for treatment of the Covered Person's Inherited Metabolic Disease.
2. Covered formulas, as mandated by Indiana State Law, will follow the same Copayments as prescription drugs or Diabetic Drugs and Supplies, if prescription drugs are carved out, as stated under Article IV, Pharmacy Services.

Exclusions

1. Oral formulas or supplements used for the dietary treatment of diseases and/or conditions other than Inherited Metabolic Diseases.
2. Parenteral formulas or supplements such as hyperalimentation
3. DME (Durable Medical Equipment) as defined by the Plan such as external ambulatory pumps and related components (See Article IV, Durable Medical Equipment)
4. Any enteral formula or supplement labeled "Caution – Limited by Federal law to Investigational Use" or experimental drugs even though a charge is made to the patient
5. Take home oral formulas or supplements and/or supplies from the Hospital
6. Convenience items, including unit of use packaging for patient convenience
7. Extra Nutrition for Inherited Metabolic Disease for vacation is limited to one override per Member per formula per year
8. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Orthotic and Prosthetic Devices**Copayment/Coinsurance Required**

20% of Eligible Expenses

1. Orthotic and Prosthetic devices are Covered when Medically Necessary and authorized in accordance with the Network's precertification process and are included on the Plan Orthotic and Prosthetic Device list.
2. Components which are integral to the function of Medically Necessary Prosthetic Devices and authorized by the Plan.
3. Repair, adjustment or replacement of the Medically Necessary Orthotic and Prosthetic Devices or components caused by normal wear or by a change in the Covered Person's condition are Covered. Therapeutic shoes or the modification of shoes are limited to one pair per year based on Medical Necessity.
4. If the Plan Orthotic and Prosthetic Coverage criteria for a custom-molded Orthotic are not met but the criteria for a custom-fitted Orthotic are met, Coverage is for the least costly alternative.

5. Coverage will not exceed the minimal alternative that is Medically Necessary to allow the Member to meet their potential functional ability.
6. One pair of refractive lenses or contact lenses following crystalline lens removal (primary cataract surgery) or the congenital absence of the lens.
7. Contact lenses as required for the treatment of keratoconus with Prior Authorization.

Exclusions

1. Eyeglasses and frames
2. Refractive lenses or contact lenses or the fitting thereof except for the first pair of refractive lenses following crystalline lens removal (primary cataract surgery) or the congenital absence of the eye or contact lenses for the treatment of keratoconus as Medically Necessary with Prior Authorization of the Plan
3. Medical Foods (e.g., Limbrel™ and Glucerna®), including maintenance enteral products (tube feedings), even when they are the primary source of nutrition, except for Nutrition for Inherited Metabolic Disease (see Article IV, Nutrition for Inherited Metabolic Disease)
4. Wigs or hair prostheses
5. Convenience or comfort items as defined by the Plan
6. Repair or replacement of lost, neglected or stolen orthotics or prosthetics
7. Duplicate orthotics or prosthetics
8. Routine service that does not require the skill of a technician
9. An option/accessory that is beneficial primarily in allowing the Member to perform leisure or recreational activity is not Covered
10. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Outpatient Services

Copayment/Coinsurance Required

To all of the following services, an additional Copayment/Coinsurance may apply. Please reference Article IV, Physician Services.

Outpatient services and supplies, including but not limited to:

Laboratory, pathology, and radiology services.	No Charge
Electrocardiography (EKG) and electroencephalography (EEG).	No Charge
High cost imaging	\$50 per visit
1. CT	
2. MRI	
3. PET	
4. SPECT	

This Copayment/Coinsurance does not apply to any other radiology or nuclear medicine service.

No Charge

- Copayment/Coinsurance Required**

\$250 per outpatient surgical admission

Physician Services

Applicable Physician Services, Non-Office Visit
Copayment will apply

Except in an Emergency, Outpatient Surgical Services may require prior authorized by the Member's Medical Network. Covered Services received by the Member include:

- ## Limitations

Authorizations for Coverage of elective surgeries will not be made by the Plan more than three (3) months prior to the date of surgery except for Transplants.

Copayment/Coinsurance Required

1. Pervasive Development Disorder (PDD) means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

2. Coverage for PDD services will be provided as prescribed by the Member's treating Participating Physician in accordance with a Treatment Plan.
3. Exclusions other than those listed in this benefit section (Article IV, Pervasive Developmental Disorders) and those that are inconsistent with the Treatment Plan do not apply.
4. The benefits for PDD are not subject to the dollar limits, Deductibles, or Copayment/Coinsurance provisions that are less favorable than the dollar limits, Deductibles, or Copayment/Coinsurance provisions that apply to physical illnesses generally. The Plan considers dollar limits and visit limits to be synonymous for purposes of this coverage.

Copayment/Coinsurance Required

Applied Behavioral Analysis (ABA) therapy	\$20 per visit
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Exclusions

1. Health Care Services for the treatment of PDD that are not prescribed by the Member's Treating Physician in accordance with a Treatment Plan
2. Services that do not provide direct patient care.
3. Travel expenses, including but not limited to mileage submitted by caregivers or program supervisors, airplane fares, room and board.
4. Any services, Hospital, professional or otherwise, which are not provided, arranged for, Prior Authorized, or approved by the Member's Primary Care Physician or Prior Authorized by the Medical Director of the Plan.
5. Workshops/Education for parents or direct service workers.
6. Diapers

Pharmacy Services

To be Covered, Drugs must be

1. An FDA approved drug requiring a prescription by Federal law except OTC Select Drugs, and
2. Indicated for the particular condition being treated. If the drug has not been approved by the FDA for the particular indication being treated, it is Covered if:
 - a. The drug is recognized for the treatment of a particular condition/type of cancer in at least one of the following standard reference compendiums: The United States Pharmacopeia Drug Information (Evidence I only will be accepted or the American Hospital Formulary Service Drug Information (from standard of care discussion as indicated by a ψ and not experimental discussion, or
 - b. The drug is demonstrated for a particular condition/type of cancer to be safe and effective in at least two (2) formal clinical studies, the results of which have been published in peer reviewed professional medical journals published in the United States, Great Britain, Canada or Australia.

A thirty (30) day supply shall not exceed one manufacturer's standard packaging, unless Medically Necessary. Examples of a manufacturer's standard packaging include but are not limited to: topical creams, solutions, gels or ointments, otics, ophthalmics, nasal or oral inhalers, a vial of insulin, a package of test strips or a box of disposable syringes.

In lieu of Brand Drugs, Generic Equivalent Drugs will be dispensed unless Brand Drugs are Medically Necessary.

<u>Pharmacy Tiers</u>	<u>Copayment/Coinsurance Required</u>
OTC Select Drugs	\$5
Generic Select Drugs	\$10
Generic Non-Select Drugs	40% of Eligible Expenses (with a minimum Copayment of \$40 and a maximum Copayment of \$100)
Brand Select Drugs	\$20
Brand Non-Select Drugs	40% of Eligible Expenses (with a minimum Copayment of \$40 and a maximum Copayment of \$100)

Mail Order - Copayment/Coinsurance by tiers listed above apply to Mail Order Pharmacy.

Prescription Drugs and Diabetic Drugs and Supplies including: Generic Select Drugs, Generic Non-Select Drugs, Brand Select Drugs, OTC Select Drugs	A ninety (90) day supply is available for two (2) thirty (30) day supply Copayment(s)/Coinsurance.
Brand Non-Select Drugs	A ninety (90) day supply of Brand Non-Select Prescription Drugs is available for three (3) thirty (30) day supply Copayment(s)/Coinsurance.

Please Note: Biopharmaceutical Drugs are not eligible for the Mail Order benefit.

Limitations

1. Quantity Limits have been placed on certain medications as a quality management measure to promote safe and appropriate utilization based on current medical literature. This list of medications is defined in the Pharmacy Program.
2. Post-pay drugs are medications that may be prescribed for a Member for a condition for which it is not FDA indicated, or for a condition which is an excluded benefit. This list of medications is determined by the Pharmacy and Therapeutics Committee. The Member will receive a partial (five (5) day) supply of the medication while a Coverage determination is made.
3. Step therapy drugs are medications that may have pre-requisite therapies as a determinate factor in directing them to a specific level of Coverage. This list of medications is defined in the Pharmacy Program. For these step therapy prescription drugs, the Plan reserves the right to ensure that the following Coverage criteria are met:
 - a. The prescription drug is for the treatment of a Covered medical condition, and
 - b. Established step therapy guidelines that are developed and maintained by the Plan are followed.
 - c. Adherence to a step-therapy program may result in a lower Copayment/Coinsurance.
4. Safety issues can dictate a medication being blocked by the Plan for drugs that pose a public health concern. Some examples may be a manufacturers' drug package insert that contains black box warnings, post marketing surveillance incident reports or as defined by the Pharmacy and Therapeutics Committee.

5. It is possible that Covered Drugs may move from one tier category to another at the discretion of the Plan as determined by the Pharmacy and Therapeutics Committee throughout the Calendar Year.
6. Some Prescription Drugs require Prior-Authorization for Coverage. This list of medications is defined in the Pharmacy Program and may change throughout the year as determined by the Pharmacy and Therapeutics Committee.
7. Extra Prescription Drugs and/or Supplies for vacation are limited to one override per member per drug per year.

Treatment Limitation(s)

Members can receive up to three (3) months of treatment for nail onychomycosis in a ninety (90) day period if approved by the Plan. This therapy is limited to one course of therapy per lifetime.

Diabetic Drugs and Diabetic Supplies

Copayment/Coinsurance Required

1. DME (Durable Medical Equipment) as defined by the Plan such as external ambulatory insulin pumps and related components (See Article IV, Durable Medical Equipment)
2. Non-prescription Diabetic Supplies as determined by the Pharmacy and Therapeutics Committee.
3. Diabetic Drugs and Diabetic Supplies Copayment/Coinsurance applies to Biopharmaceutical Drugs; whose sole FDA indication is the treatment of diabetes. Prior Authorization is required.

Family Planning Drugs

Copayment/Coinsurance Required

Contraceptive Drugs, oral, injectable (e.g., Depo-Provera®), insertable (contraceptive rings e.g., NuvaRing®) and topical (e.g., patches)

OTC Select Drugs

Copayment/Coinsurance Required

Over-the-Counter (OTC) Select Drugs mean those OTC drugs which offer additional value over comparable OTC drugs and as determined by the Pharmacy and Therapeutics Committee.

Prescription Drugs

Copayment/Coinsurance Required

Exclusions

1. Drugs not approved by the FDA or not indicated for the particular condition/type of cancer in at least one of the following standard reference compendiums: The United States Pharmacopeia Drug Information (Evidence I will only be accepted) or the American Hospital Formulary Service Drug Information (from standard of care discussion as indicated by a ψ and not experimental discussion), except as stated above under "Covered".
2. OTC (Over-the-Counter) non-prescription drugs and supplies except those identified as OTC Select Drugs
3. Prescription drugs which have an OTC equivalent
4. State restricted drugs
5. Any drug labeled, "Caution-Limited by Federal law to Investigational Use" or experimental drugs even though a charge is made to the patient
6. Take home drugs from the Hospital
7. Drugs for travel
8. Extra Prescription Drugs and/or Supplies for travel or to replace those that have been lost, stolen, broken, or destroyed
9. Vitamins not requiring a prescription by law

10. Drugs for cosmetic purposes
11. Drugs to enhance athletic performance
12. Convenience Packaging as defined in Article I, Definitions, Pharmacy Services
13. Drugs in unit dose packaging for institutional use
14. Food supplements when prescribed for the purpose of weight loss or for treatment of obesity
15. Immunizations and inoculations (vaccine and administration of vaccine) required for travel, recreational purposes or for the convenience of the patient, the patient's family, the Physician or the Provider
16. Injectable and oral vaccines are not available through the Pharmacy. (See Article IV, Physician Services)
17. Contraceptive devices.
18. Growth hormone used for conditions other than documented growth hormone deficiency, growth retardation in children with chronic renal insufficiency (CRI) up to time of renal transplantation or AIDS wasting
19. Non-sedating antihistamines or low-sedating antihistamines except those identified as OTC Select Drugs
20. Drugs used for the treatment of erectile or sexual dysfunction
21. Infertility Drugs - Oral, Biologic Products, Biopharmaceutical Drugs and Injectables {, including the associated disposable syringe and needle and the monitoring of infertility drug therapy
22. Please reference Article IV, Nutrition for Inherited Metabolic Disease for Covered formulas, as mandated by Indiana State Law
23. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Physician Services

Copayment/Coinsurance Required

Office Visits:

Primary Care Physician Office Visit	\$20 Copay per visit
Specialty and Referral Physician Office Visits	\$20 Copay per visit

An office visit Copayment may be collected when a Member has a face-to-face encounter with a Physician, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife or Advanced Practice Nurse.

Covered services and supplies include:

1. Office visits, services and supplies for the determination and/or treatment of illness. These services include medical consultations, Surgical Services and procedures performed in the Physician's office, second opinion consultations, and specialist treatment services.
2. Routine maternity care including prenatal, antepartum and postpartum care unless Member is serving in capacity as a surrogate mother. (See also Article IV, Preventive Medical Services).
3. All healthy newborn outpatient visits including routine screening.
4. Counseling, examinations or testing for contraception.
5. Allergy testing (for allergy serum/extract and allergy injections, see Article IV, Allergy Serum/Extract).
6. Diabetes self-management training, as mandated by Indiana State Law, ordered in writing by a Participating Provider and provided by a licensed, registered or certified health care professional who has specialized training in the management of diabetes. Diabetes management training may be limited to:
 - a. One or more visits after receiving a diagnosis of diabetes.

- b. One or more visits after receiving a diagnosis that represents a significant change in the Member's symptoms or condition that makes changes in the Covered Person's self management Medically Necessary.
- c. One or more visits for re-education or refresher training.

See Article IV, Outpatient Services and/or Preventive Medical Services for appropriate Copayment/Coinsurance for examinations, tests and treatments.

Non-Office Visits :

Copayment/Coinsurance Required

Primary Care Physician, Specialty and Referral Physician Visits in the Hospital or outpatient facility

No Charge

Emergency Room Physician Visits

No Charge

Surgical Physician

No Charge

Anesthesiologist

No Charge

Primary Care Physician, Specialty and Referral Physician in Home Visits, when provided by your Participating Physician

20% of Eligible Expenses

1. Surgical Services including surgical assistance and anesthesiology services performed in connection with Surgical Services.
2. Physician's services for visits and examinations, including consultation time and time for personal attendance with the Member during a confinement in a Hospital or Skilled Nursing Facility when a Member is confined in such facility.

Exclusions

1. Administrative Physical Examinations, related tests, services, supplies and reports for the maintenance or improvement of the health of a Member.
2. Immunizations and inoculations (vaccine and injection of vaccine) required for travel, including but not limited to business or recreational purposes, military service, or for the convenience of the patient, the patient's family, the Physician or the Provider
3. Allergy Serum/Extract
4. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Preventive Medical Services

Copayment/Coinsurance Required

For both Type I and Type II Preventive Medical Services, an office visit Copayment may be collected when a Member has a face-to-face encounter with a Physician, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife or Advanced Practice Nurse

Type I

(Not subject to Deductible)

Included as part of the Physician Services office visit
copayment

Type II

(Subject to Deductible)

Applicable Outpatient Services
Copayment/Coinsurance Applies

Type I:

Preventive Medical Services are only those outpatient services, as listed below, which are not subject to the Member's Medical Deductible. First day, first dollar coverage is available for Type I Preventive Medical Services. (These services may be subject to any Copayment/Coinsurance listed above.)

Periodic health examinations, including well child care, when provided by a Primary Care Physician or Obstetrician/Gynecologist (OB/GYN) in the Physician's office. The following office-based Preventive Medical Services are included:

1. History
2. Physical examination
3. Vital signs
4. Height and weight
5. Breast cancer screening tests as mandated by Indiana State Law, include:
 - i. One (1) baseline screening mammography before the age of forty (40) for a Member who is at least thirty-five (35) years old
 - ii. Annual screening mammography if at risk and less than forty (40).
 - iii. Annual screening mammography for Members forty (40) years old or older.
 - iv. Any additional mammogram views needed for proper evaluation and ultrasound services, if Medically Necessary
6. Prostate cancer screening tests (PSA), as mandated by Indiana State Law include:
 - a. At least one (1) PSA test annually for an individual who is at least fifty (50) years old.
 - b. At least one (1) PSA test annually for an individual less than fifty (50) who is at high risk of prostate cancer according to the American Cancer guidelines.
7. Pelvic examination and PAP test
8. Rectal examination and fecal occult blood testing (FOBT)
9. Immunizations and inoculations (vaccine and administration of vaccine) based on the guidelines of the Advisory Committee on Immunization Practices (ACIP), or at the Plan's discretion, other nationally recognized organizations, such as the American Academy of Pediatrics (AAP) or the Academy of Family Physicians (AAFP). Biopharmaceutical Drugs will require an additional Copayment/Coinsurance. Please see Pharmacy Services for Biopharmaceutical Drugs Copayments/Coinsurance information
10. Vision screening
11. Preventive medicine counseling
12. Prenatal care includes services mentioned above and measurements of uterine size, fetal heart tones (FHT) and urine dipstick for protein and glucose
13. Well child examinations include services mentioned above, as age appropriate and measurements of head circumference, developmental evaluation and urine dipstick.

Type II:

Preventive Medical Services are those outpatient services that **are subject** to the Member's Medical Deductible. See Article IV, Outpatient Services for appropriate Copayment/Coinsurance based on the location of the following services:

Additional Preventive Medical Services when performed or prescribed by a Primary Care Physician:

1. Screenings for children and teens:
 - a. Hereditary/metabolic screenings in newborns
 - b. Tuberculosis (Tuberculin skin test)
 - c. Lead
 - d. Hematocrit or Hemoglobin
 - e. Hearing examinations, as mandated by Indiana State Law, including an infant physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments.
 - f. Cholesterol
 - g. Chlamydia
2. Screening for adults:
 - a. Fasting lipoprotein profile
 - b. Blood sugar
 - c. Thyroid (TSH)
 - d. Osteoporosis
 - e. Menopause
 - f. Colorectal cancer screening including colonoscopy, sigmoidoscopy and barium enema, as mandated by Indiana State Law, must be Covered for any non-symptomatic individual in accordance with current American Cancer Society Guidelines for a Covered Person who is:
 - i. At least fifty (50) years of age; or
 - ii. Less than fifty (50) years of age and at high risk for colorectal cancer

Note: Screening colonoscopy requires the Outpatient Surgical Services Copayment/Coinsurance. See Article IV, Outpatient Surgical Services for Copayment/Coinsurance information.
3. Screenings for pregnancy management:
 - a. Blood type and CDE (Rh) type
 - b. Antibody screen (indirect Coombs)
 - c. D immune globulin (RhG)
 - d. Determination of immunity to rubella virus
 - e. Antibodies to hepatitis B virus surface antigen (HBsAg)
 - f. Venereal Disease Research Laboratory (VDRL)
 - g. Human immunodeficiency virus (HIV) testing
 - h. Chlamydia/Gonococcus (GC) screen
 - i. Ultrasound
 - j. Maternal-serum-alpha-fetoprotein (MSAFP)/Multiple markers
 - k. Amniocentesis/Chorionic Villus Sampling (CVS)
 - l. Genetic testing including but not limited to cystic fibrosis and Tay-Sachs
 - m. Diabetes screen/Glucose challenge test (GCT)
 - n. 3 hr. glucose tolerance test (GTT)/ 2 hr. glucose tolerance test (GTT)
 - o. Group B strep
 - p. Optional labs including hemoglobin (hgb) electrophoresis and toxoplasmosis

See Article IV, Outpatient Services, for services not mentioned above

Limitations

Coverage for annual exams/screening is available no sooner than eleven months from the previous exam.

Exclusions

1. Administrative Physical Examinations, related tests, services, supplies and reports that are not for the maintenance or improvement of the health of a Member.
2. Employer requested physical, psychological or psychiatric examinations, legally required drug testing and examination for medicolegal reasons
3. Immunizations and inoculations (vaccine and administration of vaccine) required for travel, recreational purposes, military service, or for the convenience of the patient, the patient's family, the Physician or the Provider
4. Non-routine office visits (i.e., sick visits) for the examination, diagnosis, and treatment of any condition, disease or injury. See Article IV, Physician Services
5. Tests in connection with the diagnosis of illness or injury or services/tests not listed above. See Article IV, Outpatient Services.
6. Contraceptive and procreative management. See Article IV, Physician Services and/or Pharmacy Services, Family Planning Drugs
7. Routine annual comprehensive eye examinations including refractions. See Article IV, Vision Services
8. Periodic follow-up examination for medical surveillance following treatment. See Article IV, Physician Services
9. Periodic follow-up examination for medical surveillance of patients who may have already been treated for some disease or injury not now present. See Article IV, Physician Services
10. Pre-operative examinations and related tests. See Article IV, Physician Services and/or Outpatient Services
11. Prophylactic organ or tissue removal. See Article IV, Hospital Services or Outpatient Surgical Services
12. Counseling, examinations or testing for contraception. See Article IV, Physician Services
13. Genetic tests, except for routine testing during pregnancy. See Article IV, Genetic Testing
14. Examinations and tests for conditions or symptoms identified or discovered during routine periodic examinations. See Article IV, Physician Services and/or Outpatient Services
15. Prescription drugs for the prevention of disease. See Article IV, Pharmacy Services
16. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Reconstructive Surgery**Copayment/Coinsurance Required**

Subject to Hospital Inpatient Copayment/Coinsurance

Coverage is provided for Reconstructive Surgery for the prompt (i.e., as soon as medically feasible and medically appropriate) repair of birth or growth defects, accidental injury or for the improvement of impaired physiological functioning of the body resulting from disease, birth or growth defects or accidental injury. (For Reconstructive Services following mastectomy, please see Article IV, Mastectomy Services).

Limitations

Authorizations for Coverage of elective surgeries will not be made by the Plan more than three (3) months prior to the date of surgery.

Exclusions

1. Cosmetic or reconstructive services and procedures and all associated expenses including, but not limited to, pharmacological regimens, nutritional services, aesthetic Reconstructive Surgery, salabrasion, chemosurgery or other such skin abrasion procedures associated with the removal of scars, tattoos, or age spots. Psychological reasons are not considered an argument for Coverage.

2. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

**Rehabilitation Therapy - Occupational,
Physical and Speech**

Copayment/Coinsurance Required

Inpatient Therapy

Inpatient therapy visits are unlimited.

Confinements in a Hospital,
Rehabilitation or Skilled Nursing
Facility

Subject to applicable Hospital Inpatient
Copayment/Coinsurance

Outpatient Therapy:

Outpatient Therapy services are limited to twenty-five (25) visits per Calendar Year.

Each outpatient therapy visit counts as one (1) visit toward the twenty-five (25) visit limit even when multiple outpatient therapy visits are received on the same day.

Occupational therapy \$20 per visit

Physical therapy \$20 per visit

Speech therapy \$20 per visit

Inpatient and outpatient occupational, physical and speech therapy for treatment of acute illness or injury are Covered only if and to the extent that significant potential exists for progress toward a previous level of functioning as determined by the Member's Primary Care Physician and Medical Network or a Plan Medical Director. Acute is defined as having rapid onset, severe symptoms and a defined course. Therapy services are further limited to twenty-five (25) visits per condition per Calendar Year for all therapies combined. For cardiac rehabilitation Coverage see Article IV, Cardiac Rehabilitation.

Exclusions

1. Rehabilitation therapy for non-acute illness or injury as determined by the Plan Member's Primary Care Physician and Medical Network
2. Behavioral training, approaches that use classical or operant conditioning and/or interventions that focus on skills training (Examples include, but are not limited to, functional analysis, assertiveness training, smoking cessation, stress management, progressive muscle relaxation)
3. Remedial education testing to evaluate school performance and/or diagnose or treat learning disabilities
4. Developmental testing after diagnosis
5. Sensory integration therapy
6. Auditory integration therapy
7. Alternative/Complimentary medicine therapies, including but not limited to, aromatherapy, depuration (except for chelation for iron or lead poisoning), herbal remedies, hypnotherapy and massage therapy
8. Acupuncture, biofeedback, hippotherapy and chiropractic services
9. Naturopathic and Christian Science practitioners

10. Equipment for use in exercising or training, including but not limited to, devices for home use ordered in conjunction with rehabilitation therapies (e.g., exercise putty, exercise bands or exercise balls)
11. General exercise programs such as athletic training, body building, aquatic exercise programs, fitness, flexibility and diversion or general motivation and work hardening
12. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Surgical Dressings

Copayment/Coinsurance Required

20% of Eligible Expenses

Surgical dressings applied by the Member in the home are Covered when Medically Necessary and authorized by a Plan Physician and the Plan, and included on the Plan's Surgical Dressing List.

Exclusions

1. Surgical dressings applied by the Member, which have not been authorized by a Plan Physician and the Plan
2. Surgical dressings used primarily for Member convenience
3. Surgical dressings that are not part of a Physician directed Home Health care plan
4. Take home surgical dressing supplies from a Hospital or Physician's office, except for surgical dressings authorized by the Plan
5. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Temporomandibular Joint Dysfunction or Disease (TMJ)

Copayment/Coinsurance Required

Subject to applicable Copayment/Coinsurance

Physician Services

Applicable Physician Services, Non-Office Visit
Copayment will apply

Medical services for the treatment of Temporomandibular Joint Dysfunction or Disease (TMJ) covered when Medically Necessary and approved by the Primary Care Physician and the Plan's Medical Director; due to injury or medical condition.

Exclusions

1. Dental services for the treatment of Temporomandibular Joint Dysfunction (TMJ) or disease
2. Conventional or surgical orthodontics
3. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Transplants - Organ, Tissue and Bone Marrow

Copayment/Coinsurance Required

\$2,000 copay

Physician Services

Applicable Physician Services, Non-Office Visit
Copayment will apply}

The Lifetime Maximum benefit per Member for all transplant services under this Group Service Agreement is one million dollars (\$1,000,000) per Covered Person. The Lifetime Maximum for Transplant Services does not accumulate towards the Lifetime Maximum for this Group Service Agreement. Pharmacy Services do not accumulate to the Transplant Maximum.

Transplant services are covered only when the transplant recipient is a Member of the Plan.

Benefit Period: Total of three hundred and sixty-five (365) days beginning one (1) day immediately prior to a Covered Transplant Procedure or first (1st) myeloblation therapy (high dose chemotherapy and/or irradiation).

Eligible medical expenses include the following:

Any of the following Medically Necessary human organ and tissue transplants:

Adult Procedures

1. Bone marrow or stem cell including:
 - a. Autologous bone marrow including high dose chemotherapy
 - b. Related allogeneic bone marrow including high dose chemotherapy
 - c. Unrelated allogeneic bone marrow including high dose chemotherapy
2. Heart
3. Heart/Lung
4. Lung
5. Liver
6. Pancreas and kidney when performed simultaneously or pancreas transplant after a kidney transplant (Kidney transplant alone may be covered under medical and is not part of this transplant benefit)
7. Cornea
8. Kidney

Pediatric Procedures

1. Bone marrow and stem cell including:
 - a. Autologous bone marrow including high dose chemotherapy
 - b. Related allogeneic bone marrow including high dose chemotherapy
 - c. Unrelated allogeneic bone marrow including high dose chemotherapy
2. Heart
3. Liver
4. Cornea
5. Kidney

Transplant Related Expenses

Transplant related expenses mean Medically Necessary items that are required as a result of a Covered transplant procedure and would not be incurred if the Member were not having a Covered transplant procedure. Services related to diagnosis causing the need for a Covered transplant procedure which would have been performed whether or not the Member received a Covered transplant procedure are not considered a transplant related expenses. Transplant related expenses during a transplant benefit time period include only the following:

1. Acquisition costs, also referred to as procurement (live or cadaver). Acquisition costs include Medically Necessary services in connection with the preparation, harvesting and storage of bone marrow, stem cell or solid organ for a Covered transplant. For a living donor, acquisition costs also include the Medically Necessary Inpatient services for the recovery of the donor post surgery and any complications that arise as a direct result of the actual acquisition procedure for a period of six weeks from the date of the acquisition or as otherwise determined within the limits determined by the Plan. Cord blood is payable if the transplant is approved. Harvesting and storage of cord blood, bone marrow or stem cells for a possible future transplant is not eligible under this transplant benefit.
2. Hospital charges and professional fees for the Covered transplant procedure.
3. Inpatient services, outpatient services or Home Care Services for treatment of complications of bone marrow or stem cell transplant or for complications and/or rejection of the transplanted organ.
4. Physician fees for Medical Care following Hospital discharge, which are identified as post transplant.

Exclusions and Limitations

1. Transplants are not Covered unless provided in a Hospital approved by the Member's Medical Network or the Plan
2. Medical and Hospital services of a donor or prospective donor when the recipient of the transplant is not a Member of the Plan
3. Health Care Services and associated expenses for transplants involving mechanical or animal organs
4. Transplantation of two (2) or more organs simultaneously unless prior authorized by the Plan
5. Neither the Plan nor its Participating Providers assure the availability of organs for transplant
6. Transplant related services for any potential/prospective donor, unless the transplant procedure has been prior approved by the Plan
7. Experimental/research medical, surgical, and pharmacological regimes, and associated Health Care Services, and/or those services or procedures that are not consistent with accepted standard medical practice
8. Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Urgent Care Services

Physician office visits

Emergency room visit

Immediate/Urgent Care Center visit

Copayment/Coinsurance Required

\$20 Copay per visit

\$75 per emergency room visit. Waived if admitted as a Hospital Inpatient

\$35 Copay per visit

For Urgent Care Services, the Covered Person must contact his/her Participating Primary Care Physician unless the Covered Person is beyond a fifty (50) mile radius of his/her Primary Care Physician's office. When outside the fifty (50) mile radius of the Primary Care Physician's office, a referral from a Participating Provider is not required before seeking treatment, however, continued care Out-of-Network is not Covered unless referred by the Primary Care Physician and Prior Authorized by the Member's Medical Network.

Exclusions

Please reference Article V, General Exclusions and Limitations, for exclusions *in addition* to any listed with the benefits in this Article.

Vision Care**Copayment/Coinsurance Required**

1. Medical eye care, consisting of an examination of the eye(s) and refraction that is Medically Necessary due to an existing medical condition, disease or injury to the eye, or a therapeutic intervention, is a covered service. Examinations are covered when Medically Necessary and performed by a Participating Provider with a Primary Care Physician referral and network authorization, if required.
2. Medical and surgical treatment of diseases of the eye.

Exclusions

1. Services which are not Medically Necessary or not required in accordance with accepted standards of medical practice. For example, radial keratotomy [photorefractive keratectomy (PRK) and ophthalmic training (eye training) for the treatment of reading, behavioral, and emotional disorders.]
2. Eye refractions, corrective lenses and frames. Services which are not Medically Necessary or not required in accordance with accepted standards of medical practice. For example, radial keratotomy [photorefractive keratectomy (PRK) and ophthalmic training (eye training) for the treatment of reading, behavioral, and emotional disorders.]
3. Corrective lenses and frames except as listed above
4. Contact lenses and associated services, including examination and fittings except as listed above
5. Eye exercises (see Non-Covered Services, item number 1)
6. Replacement of lenses due to loss, theft, or neglect
7. Contact lenses and associated services, including examination and fittings
8. Eye exercises
9. Replacement of lenses due to loss, theft, or neglect

ARTICLE V - GENERAL EXCLUSIONS AND LIMITATIONS

General Exclusions

The following services and benefits are NOT Covered by the Plan. Please refer also to the specific exclusions that are listed with the Covered benefits in Article IV.

- A. Any services, Hospital, professional or otherwise, which are not provided, arranged for, authorized or approved by the Member's Primary Care Physician or authorized by the Medical Director of the Plan. This limitation shall not apply to Emergency Services. The Plan reserves the right to evaluate and determine Coverage of care not directly provided or Prior-Authorized by Primary Care Physicians. Emergency Services Coverage shall only provide for care that is Medically Necessary for the treatment of the Medical Emergency and shall be subject to the terms, conditions, exclusions and limitations of this Agreement.
- B. Any medical service, prescription drug, medicine, equipment, supply or procedure directly or indirectly related to a service which is not Medically Necessary or which is not a Covered service in part or in full. Services, recommended by a Participating Physician, that are not services Covered by the Plan.
- C. Services that are not Medically Necessary or not required in accordance with accepted standards of medical practice.
- D. Personal comfort or convenience items in and out of the Hospital such as television, telephone, private room (unless Medically Necessary), housekeeping, homemaker service, and room and board as part of Home Health Care.
- E. Special diets at home including but not limited to , supplemental feedings (e.g., Slimfast™, Ensure™, Sustacal™) except for Nutrition for Inherited Metabolic Disease (see Article IV, Nutrition for Inherited Metabolic Disease).
- F. Private duty nurse unless determined to be Medically Necessary.
- G. Conventional or surgical orthodontics.
- H. Conventional or surgical orthognathics, unless Medically Necessary as determined at the Plan's sole discretion.
- I. Orthoptics or vision training and any associated supplemental testing.
- J. Custodial care, nursing home care, rest cures, domiciliary care regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities.

- K. Experimental/investigational medical, surgical, or psychiatric procedures and pharmacological regimens, and associated Health Care Services, and/or those services or procedures that are not consistent with accepted standard medical practice, or services requiring approval by any governmental authority prior to use where such approval has not been granted or services not approved for Coverage by Medicare.
- L. Any care for military service connected disabilities and conditions that the Member is entitled to receive, if reasonably available, and actually received in a Veteran's Administration Hospital, clinic, or other facility in which the Member is entitled to benefits. Any care for conditions that federal, state or local law requires to be treated in a public facility.
- M. Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy or counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs and all other procedures and equipment developed for or used in the treatment of impotency and all related diagnostic testing.
- N. Weight management programs such as, but not limited to Jenny Craig[®], Optifast[®] and Weight Watchers[®].
- O. Care of flat feet; supportive devices of the foot, such as arch supports or pelvic/spinal stabilizers (even if specifically made for and fitted to a particular individual); care or treatment of corns, bunions and callouses of the feet, nails of the toes including clipping, debriding and treatment for ingrown toenails, care of fallen arches, weak feet or chronic foot strain, hypertrophy or hyperplasia of the skin of the feet unless Medically Necessary because of diabetes or circulatory problems.
- P. Out-of-Network Services rendered to the Covered Person while traveling, which could reasonably have been foreseen by the Member prior to leaving and/or against Physician advice. For example, medical and Hospital costs resulting from a normal full-term delivery of a baby, except those services Prior Authorized in writing by the Plan.
- Q. Travel and transportation as a treatment modality or to receive consultation or treatment. Transportation costs for a living donor.
- R. Hair analysis unless used as a diagnostic tool for heavy metal poisoning.
- S. Services for injuries or illnesses arising out of or in the course of the Member's employment that are Covered under any worker's compensation or occupational disease act or law.
- T. Benefits otherwise provided in this Certificate, which the Plan is unable to provide because the benefit is illegal.
- U. Any service or benefit not expressly Covered under this contract even if provided or referred by a Participating Provider.
- V. Services rendered prior to the effective date of Coverage or subsequent to termination.
- W. Maternity care related to a Member's serving in the capacity of a surrogate mother.
- X. Home birth services and birth centers.

- Y. Immunizations for travel.
- Z. Sensory integration therapy.
- AA. Auditory integration therapy.
- BB. Services or supplies for or related to developmental delays except for Pervasive Developmental Disorders. (See Article IV, Pervasive Developmental Disorders), learning disabilities, hyperkinetic syndromes or mental retardation. Behavioral training and remedial education.
- CC. Developmental testing after diagnosis.
- DD. Testing to evaluate school performance and/or diagnose or treat learning disabilities.
- EE. Alternative/Complimentary medicine therapies, including but not limited to, acupuncture, aromatherapy, biofeedback, chiropractic services, depuration (except for chelation for iron or lead poisoning), herbal remedies, hypnotherapy and massage therapies.
- FF. Naturopathic and Christian Science practitioners.
- GG. Marriage counseling.
- HH. Take home and over-the-counter drugs and non-diabetic supplies that do not require a prescription by Federal Law.
- II. Services, supplies, drugs or care that is provided, performed or ordered by an immediate family member (i.e., the Member, the Member's spouse or a child, brother, sister or parent of the Member's spouse) or Member of the household.
- JJ. Treatment for hair loss or hair removal regardless of medical condition or cause.
- KK. Health Care Services resulting from a Member's participation in a riot or insurrection, or received while in the commission of a felony, or in the case of a minor, for an offense that would be a felony if committed by an adult. Services, supplies or other care required while incarcerated in a federal, state or local penal institution or required while in the custody of federal, state or local law enforcement authorities, including work release programs.
- LL. Dental services for the treatment of Temporomandibular Joint Dysfunction (TMJ) or disease.
- MM. Hearing Aids and Related Services.
- NN. Vision care and materials except for Medically Necessary treatment for existing medical condition, disease or injury to the eye.
- OO. Services and supplies for Skilled Nursing Facilities.
- PP. Telephone consultations, charges for failure to keep a scheduled visit.
- QQ. Services which are solely performed to preserve the present level or function or prevent regression of functions for an illness, injury or condition which is resolved or stable.

Limitations

The rights of Members and obligations of the Plan and its Participating Providers hereunder are subject to the following limitations:

A. Circumstances Beyond Control of the Plan

Should circumstances arise not reasonably within the control of the Plan (including but not limited to major disasters, epidemics, complete or partial destruction of buildings or facilities, riots, civil insurrection) that cause delay or impracticality in provision of Health Care Services under this contract, the Plan will make a good faith effort to arrange for alternative methods of providing Coverage. In such event, the Plan will arrange for the provision of Covered services to the extent practical, but neither the Plan nor its Providers shall incur liability or obligation for any delays in providing or arranging such Coverage.

B. Limitations on Choice of Providers

Members of the Plan must use the Plan's Participating Providers as explained in this contract. The Plan's Participating Providers may be subject to change from time to time with respect to individual practitioners, organizations or institutions. The Plan does not guarantee the length of service for any of its Participating Physicians, Hospitals or providers.

**ARTICLE VI - SEEKING MEDICAL CARE, INCLUDING EMERGENCY SITUATIONS AND
CHANGING PRIMARY CARE PHYSICIANS**

- A. In all circumstances, Covered Persons are required to contact their Primary Care Physician for advice and concurrence prior to seeking medical care, including health maintenance and preventive services, unless the nature of an Emergency condition effectively precludes such action unless specified otherwise herein.
- B. If a Covered Person is hospitalized under an Emergency condition, the Covered Person or the Subscriber in the case of a minor Covered Person must notify the Plan of the fact of the Covered Person's hospitalization and must request the transfer of the Covered Person's care to a Primary Care Physician. Notification and request for care from a Primary Care Physician should be received by the Plan within a period of forty-eight (48) hours if the Covered Person is hospitalized beyond forty-eight (48) hours. In the case of a Covered Person who by reason of medical condition is unable to communicate said forty-eight (48) hours, shall be extended until forty-eight (48) hours after the Covered Person regains the ability to communicate.
- C. A Covered Person may change Primary Care Physicians within the same Network every ninety (90) days, but no more frequently than twice yearly. A Covered Person may change their Network only during an Open Enrollment period except when the Covered Person moves into a new Network Service Area. This change may be accomplished by completing the required paperwork at least two (2) weeks before that change is to take effect or by contacting Member Services, either by telephone, email, mail or facsimile, as appropriate. Other than an Emergency situation, should a Covered Person go to a Physician other than the Primary Care Physician designated in writing to the Plan or to a Physician referred by the designated Primary Care Physician, the benefits of this Plan may not be paid.
- D. A Covered Person is responsible for presenting their insurance information, including M•Plan Membership Card, to the provider at the time of service. Failure to do so within ninety (90) days will result in denial of claim for service.

ARTICLE VII - MEDICAL REFERRALS AND CASE MANAGEMENT

A. Medical Referrals

A Primary Care Physician will determine the need for referrals and make necessary medical referrals of Covered Persons to other Participating Providers.

A Primary Care Physician will make necessary referrals of Covered Persons to other Participating Providers, except when there is no Participating Provider for the type needed In-Network.

Some services may require Prior Authorization by the Covered Person's Network.

B. Case Management

Cases accepted into the case management program by the Utilization Review Department may, under the approval of the Medical Director and the department head, utilize a cost effective alternative treatment protocol where benefits are not enumerated in the benefit plan if it does not compromise quality of care.

ARTICLE VIII - EXPERIMENTAL EXCLUSION PROCESS AND DECISION-MAKING
CRITERIA

Experimental treatment evaluations will be based on the existence of any of the following:

1. Whether or not approval from the Food and Drug Administration (FDA) exists at the time of use or proposed use;
2. The treatment is the subject of a current investigational new drug or new device application on file with the FDA;
3. The treatment is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or
4. The treatment is being provided pursuant to a written research protocol which describes among its objectives, determinations of safety, efficacy in comparison to conventional alternatives, toxicity;
5. The treatment is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board ("IRB") as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services ("HHS").
6. The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research setting or that the treatment is not effective;
7. The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity or effectiveness compared with conventional alternatives; or
8. There is insufficient support in peer-reviewed literature for safety and/or efficacy as determined by the Plan's Technology Assessment Committee (TAC); or
9. The treatment is not investigational in itself pursuant to the above and would not be Medically Necessary, but for the provision of a drug, device, treatment or procedure which is Experimental.

ARTICLE IX - COORDINATION OF BENEFITS, SUBROGATION

A. Model COB Contract Provisions

Coordination of this Group contract's Benefits with other Benefits. This coordination of benefits (COB) provision applies when a person has health Coverage under more than one plan. "Plan" is defined below. The order of benefit rules below determine which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

B. Definitions

1. A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated Coverage for Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - a. "Plan" includes: group insurance, closed panel or other forms of group or group-type Coverage (whether insured or uninsured); Hospital indemnity benefits in excess of \$200 per day; medical care components of group long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; other governmental benefits, as permitted by law.
 - b. "Plan" does not include: individual or family insurance; closed panel or other individual Coverage (except for group-type Coverage); amounts of Hospital indemnity insurance of \$200 or less per day; school accident type Coverage; benefits for non-medical components of group long term care policies; Medicare, Medicare supplement policies, Medicaid policies, and Coverage under other governmental plans, unless permitted by law.
 - c. Each contract for Coverage under (a) or (b) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.
2. The order of benefit determination rules determine whether this Plan is a "primary plan" or "secondary plan" when compared to another plan covering the plan. (Member or Person?)

When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

3. "Allowable expense" means a health care service or expense, including deductibles and Copayments, that is Covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not Covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses.
 - a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides Coverage for Hospital private rooms) is not an allowable expense.
 - b. If a person is Covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

- c. If a person is Covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
 - d. If a person is Covered by one plan that calculates its benefits or services on the basis of usual or customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.
 - e. The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, precertifications of admissions and preferred Provider arrangements.
4. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no Coverage under this Plan, or before the date this COB provision or a similar provision takes effect.
 5. "Closed panel plan" is a plan that provides health benefits to Covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel Member.
 6. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
 7. "Covered Persons with End Stage Renal Disease." The Plan's payer status with respect to Covered Persons entitled to or eligible for Medicare on the basis of end stage renal disease shall be determined as follows:
 - a. In the event a Covered Person becomes eligible for or entitled to Medicare on the basis of end stage renal disease and the Plan is not the primary payer under this Article IX prior to such eligibility or entitlement, Medicare shall be the primary payer of benefits and the provisions of Article IX of the Plan shall apply to Covered charges payable by the Plan.
 - b. In the event a Covered Person becomes entitled to Medicare on the basis of age or disability at the onset of or during the thirty (30) month period following entitlement or eligibility due to end stage renal disease, the Plan shall be the primary payer of benefits throughout the entire thirty (30) month period and Covered charges payable under the Plan will not be reduced by any amounts payable under Medicare.
 8. "Medicare as Primary Payer." The following rules shall apply in the event Medicare is the primary payer of medical benefits for a Covered Person pursuant to applicable federal law:
 - a. Covered charges that would otherwise be payable under this Plan for any Health Care Services shall first be determined without regard to the amount of benefits payable under Medicare, and then reduced (but not below zero) by the amount of benefits payable under Medicare.
 - b. In the event a Covered Person incurs charges for Health Care Services from a Participating Medicare Provider or a Provider who is not a Participating Medicare Provider but is accepting payment on an assignment-related basis, such charges shall not be Covered charges to the extent they exceed the allowable charge under the fee schedule used by Medicare for such Provider or Participating Medicare Provider.

- c. In the event a Covered Person incurs charges for Health Care Services from a Provider who is not a Participating Medicare Provider and is not accepting payment on an assignment-related basis, such charges shall not be Covered charges to the extent they exceed 115% of the allowable charge under the fee schedule used by Medicare for such Provider or other applicable limit.

In addition to the rights and authorities set forth herein, the Plan Administrator reserves the right to use its discretion in determining which limit(s) is/are applicable to charges incurred by a Covered Person for Health Care Services from a Provider who is not a Participating Medicare Provider and is not accepting payment on an assignment-related basis.

9. "Deemed Entitlement to Medicare." Any Covered Person who is an eligible retiree or the spouse of an eligible retiree shall be deemed to have enrolled for all Medicare Part A and Part B Coverage for which such Covered Person is eligible at the time such Covered Person first becomes eligible as if such Covered Person were enrolled in all such Medicare Coverage.
10. "Compliance with Medicare Secondary Payer Rules." Article IX shall be interpreted and administered in accordance with Section 1862 of the Title XVIII of the Social Security Act and any regulation or other official guidance issued thereunder. In the event of a conflict between this Article IX and such statute, regulation or guidance, such statute, regulation or guidance shall govern.

C. Order of Benefit Determination Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
2. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary Coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical Coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type Coverages that are written in connection with a closed panel plan to provide Out-of-Network benefits.
3. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
4. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - a. Non-Dependent or Dependent. The plan that covers the person other than as a Dependent (for example, as an employee, Member, Subscriber or retiree) is primary, and the plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as other than a Dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, Member, Subscriber or retiree is secondary, and the other plan is primary.
 - b. Child Covered Under More Than One Plan. The order of benefits when a child is Covered by more than one plan is:
 - i. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 1. The parents are married;
 2. The parents are not separated (whether or not they have ever been married);
 3. A court decree awards joint custody without specifying that one party has the responsibility to provide health care Coverages;

4. If both parents have the same birthday, the plan that Covered either of the parents longer is primary.
- ii. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care Coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the decree.
- iii. If the parents are not married, or are separated (whether or not they ever have been married) or divorced, the order of benefits is:
 1. The plan of the custodial parent;
 2. The plan of the spouse of the custodial parent;
 3. The plan of the non-custodial parent; and then
 4. The plan of the spouse of the non-custodial parent.
- c. Active Or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person were an Eligible Dependent of a person Covered as a retiree and an employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided for an individual as a retired worker and as an Eligible Dependent of an actively working spouse will be determined under this rule labeled B (9).
- d. Continuation of Coverage. If a person whose Coverage is provided under a right of continuation provided by federal or state law also is Covered under another plan, the plan covering the person as an employee, Member, Subscriber or retiree (or as the person's Dependent) is primary, and the continuation Coverage is secondary. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- e. Longer or Shorter Length of Coverage. That plan that Covered the person as an employee, Member, Subscriber or retiree longer is primary.
- f. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

D. Effect On The Benefits of This Plan

1. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this plan to pay any allowable expenses, not otherwise paid during the claims determination period. As each claim is submitted, this plan will:
 - a. Determine its obligation to pay or provide benefits under its contract;
 - b. Determine whether a benefit reserve has been recorded for the Covered person;
 - c. Determine whether there are any unpaid allowable expenses during the claims determination period.

If there is a benefit reserve, the secondary plan will use the Covered Person's benefit reserve to pay up to 100% of total expenses incurred during the claims determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claims determination period.

2. If a Covered Person is enrolled in two or more closed panel plans, and if for any reason (including the provision of service by a non-panel Provider), benefits are not payable by one closed panel plan. COB shall not apply between that plan and other closed panel plans.

E. Right To Receive and Release Needed Information

Certain facts about health Coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Each person claiming benefits under this Plan must give Plan any facts it needs to apply those rules and determine benefits payable. Failure to comply may result in non-payment of claims.

F. Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Plan. Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

H. Subrogation

Subrogation is the substitution of one person or entity in the place of another with reference to lawful claim, demand or right. The Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, of any Covered Person from any person or entity, including his or her employer, for the reasonable value of services provided under the Group Service Agreement. The Plan may require assignment to the rights of recovery from the Covered Person, to the extent of the reasonable cash value of services and benefits provided by it plus reasonable costs of collection. Covered Persons agree to reimburse the Plan for any such services whether the benefits paid arise from any person, corporation, entity, no-fault Coverage, liability insurance of any person, underinsured motorists Coverage, medical pay coverage under a homeowners’ insurance policy, automobile insurance policy, and other insurance policies or funds.

M•Plan will be entitled to the reimbursement from any recovery (whether by way of settlement, arbitration, award, or in satisfaction of a judgment and irrespective of whether the recovery is deemed or characterized as a recovery for medical expenses, pain and suffering, attorneys’ fees, any other elements of damages) even if that recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate the Covered Person or dependent for the injury or illness.

The Covered Person shall cooperate with the Plan in protecting the Plan's legal rights under these subrogation provisions and acknowledges that the Plan's subrogation rights shall be considered as the first priority claim against any person or entity, to be paid before any other claims which may exist are paid, including claims for general damages by the Covered Person. M•Plan will automatically have a lien upon any amounts the Covered Person or dependent recovers from a third party to the extent of the benefits paid by M•Plan arising out of the applicable injury or illness for which the recovery is made. The Covered Person may be required to sign a document to this effect before M•Plan will pay any benefits.

The Covered Person shall do nothing to prejudice the Plan's right under this provision, either before or after the need for services or benefits under the Group Service Agreement. The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including the right to bring suit in the name of the Covered Person. The Plan may collect, at its option, amounts from the proceeds of any settlement or judgment that may be recovered by the Covered Person or his or her legal representative, regardless of whether or not the Covered Person whether or not the Covered Person has been fully compensated. Any proceeds of settlement or judgment shall be held in trust by the Covered Person for the benefit of the Plan under these subrogation provisions, and the Plan shall be entitled to recover reasonable attorney fees from the Covered Person incurred in collecting proceeds held by the Covered Persons.

In the event a Covered Person or Eligible Dependent settles, recovers or is reimbursed by any third party or Coverage, the Covered Person or Eligible Dependent agrees to hold any such funds received in trust for the benefits of the Plan, and to reimburse the Plan for all benefits paid or that will be paid as a result of the injury or condition.

The Covered Person and Eligible Dependent(s) agree that they will make a decision on whether to pursue any claims for recovery against third parties within ninety (90) days of the date of the accident or occurrence that led to the injury or condition for which the Plan benefits are sought, and will so notify M•Plan in writing within that ninety (90) day period. In the event the Covered Person or Eligible Dependent decides not to pursue any and all third parties or fails to notify M•Plan within ninety (90) days of the accident or occurrence of its intent not to do so, the Covered Person and any Eligible Dependent(s) authorize M•Plan to pursue, sue, compromise or settle any claims in their name, agree to execute any and all documents necessary for M•Plan to pursue the claims and agrees to cooperate fully with M•Plan in the prosecution of any such claims. M•Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person or Eligible Dependent pursuing a claim against any third party or Coverage.

If the Covered Person or any of the Covered Person's Dependents fail to comply with the Subrogation provisions set out above, M•Plan has the right to terminate the Coverage of the Covered Person and Dependents under this Plan.

I. Effect of Medicare

The provisions of this section shall apply to any Covered Person who is an eligible employee, an eligible retiree, or the spouse of an eligible employee or eligible retiree and who is eligible for Medicare Coverage.

J. Eligible Employees and Spouses

In the event a Covered Person attains age sixty-five (65) and is either an Eligible or the spouse of an Eligible Employee, the Covered Person may elect to have either the Plan or Medicare be the primary payer of medical benefits. In the event the Covered Persons designates the Plan as primary payer, Covered charges payable under the Plan will not be reduced by any amounts payable under Medicare. In the event the Covered Person designates Medicare as the primary payer, the provisions of Deemed Entitlement to Medicare shall not apply and the Covered Person's Coverage under the Plan shall cease.

K. Eligible Retirees and Spouses

In the event an eligible retiree or the spouse of an eligible retiree attains age sixty-five (65) and is not Covered under an employer group health plan by virtue of the individual's current employment status under section 1862 (b) of the Social Security Act, Medicare shall be the primary payer of benefits and the provisions of Deemed Entitlement to Medicare shall apply to Covered charges payable by the Plan. Any Covered Person who is an eligible retiree, or the spouse of an eligible retiree shall be deemed to have enrolled for all Medicare Part A and Part B Coverage for which such Covered Person is eligible at the time such Covered Person first becomes eligible as if such Covered Person were enrolled in all such Medical Coverage.

L. Covered Persons With End Stage Renal Disease

The Plan's payer status with respect to Covered Persons entitled to or eligible for Medicare on the basis of end stage renal disease shall be determined as follows:

1. In the event a Covered Person becomes eligible for or entitled to Medicare on the basis of end stage renal disease and the Plan is not the primary payer prior to such eligibility or entitlement, Medicare shall be the primary payer of benefits and the provisions of Deemed Entitlement to Medicare of the Plan shall apply to Covered charges payable by the Plan.
2. In the event a Covered Person becomes entitled to Medicare on the basis of age or disability at the onset of or during the thirty (30) month period following entitlement or eligibility due to end stage renal disease, the Plan shall be the primary payer of benefits throughout the entire thirty (30) month period and Covered charges payable under the Plan will not be reduced by any amounts payable under Medicare.
3. After the thirty (30) month period, the provisions of "Deemed Entitlement to Medicare" shall apply.

M. Medicare as Primary Payer

The following rules shall apply in the event Medicare is the primary payer of medical benefits for a Covered Person pursuant to applicable federal law:

1. Covered charges that would otherwise be payable under this Plan for any Health Care Services shall first be determined without regard to the amount of benefits payable under Medicare, and then reduced (but not below zero) by the amount of benefits payable under Medicare;
2. In the event a Covered Person incurs charges for Health Care Services from a Participating Medicare Provider or a Provider who is not a Participating Medicare Provider but is accepting payment on an assignment-related basis, such charges shall not be Covered charges to the extent they exceed the allowable charge under the fee schedule used by Medicare for such Provider or Participating Medicare Provider.

3. In the event a Covered Person incurs charges for Health Care Services from a Provider who is not a Participating Medicare Provider and is not accepting payment on an assignment-related basis, such charges shall not be Covered charges to the extent they exceed 115% of the allowable charge under the fee schedule used by Medicare for such Provider or other applicable limit.

In addition to the rights and authorities set forth herein, the Plan administrator reserves the right to use its discretion in determining which limit(s) is/are applicable charges incurred by a Covered Person for Health Care Services from a Provider who is not a Participating Medicare Provider and is not accepting assignment-related basis.

N. Deemed Entitlement To Medicare

Any Covered Person who is an eligible retiree, or the spouse of an eligible retiree shall be deemed to have enrolled for all Medicare Part A and Part B Coverage for which such Covered Person is eligible at the time such Covered Person first becomes eligible as if such Covered Person were enrolled in all such Medical Coverage.

O. Certain Working Aged

For individuals age sixty-five (65) and over who have group health plan Coverage as a result of their current employment status or the current employment status of a spouse of any age in a group with less than twenty (20) employees, the "Deemed Entitlement to Medicare" rule shall apply and the Plan will only pay secondary benefits.

P. Non-Working Subscribers Under Age Sixty-Five (65)

The Plan will apply the "Deemed Entitlement to Medicare" rule to non-working, Medicare-eligible Subscribers under the age of sixty-five (65) following the rules applicable to the particular condition on which the individual's Medicare eligibility is based.

Q. Certain Disabled Persons

The Plan will apply the "Deemed Entitlement to Medicare" rule to disabled individuals under age sixty-five (65) whose Coverage comes through a plan other than a large Group. A large Group is offered through an Employer Group or employer organization with one hundred (100) or more full-time or part-time employees. It also applies to individuals who are under 65 years, entitled to Medicare on the basis of disability and who are not covered under a large group by virtue of the individual's or a family member's current employment status.

R. Compliance With Medicare Secondary Payer Rules

This section shall be interpreted and administered in accordance with section 1862 of the Title XVIII of the Social Security Act and any regulation or other official guidance issued thereunder. In the event of a conflict between this Article IX and such statute, regulation or guidance, such statute, regulation or guidance shall govern.

ARTICLE X - GENERAL PROVISIONS

- A. No statement by the Subscriber in his Enrollment Application shall void his Coverage hereunder or be used in legal proceedings hereunder unless such Enrollment Application or any exact copy thereof is included in or attached to his Member materials. All statements made by the Subscriber shall be deemed representations and not warranties.
- B. All benefits payable hereunder shall be paid to the Provider of service rendering the service and billing for same. Indemnity in the form of cash will not be paid to any Covered Person except in reimbursement for payments made by the Covered Person to a Physician or other Provider of service for which the Covered Person has express Prior Authorization by the Plan, and for which the Plan was liable at the time of payment. As soon as practical, the person making claim for cash reimbursement for benefits provided under provisions in Article IV shall give to the Plan written proof of claim including full particulars of the nature and extent of the illness, injury or condition and treatment received and contemplated, and such other information as may assist the Plan in determining the amount due and payable. Proof of claims must be filed within one year of the date of service in order to receive payment.
- C. No action at law or inequity shall be brought to recover on this Agreement or on any Subscriber certificate or Member materials issued pursuant hereto prior to the expiration of sixty (60) days after proof of claim has been filed in accordance with requirements of this Agreement nor after ten (10) years from the expiration of the time within which proof of claim is required to be furnished under this Agreement or under any Subscriber certificate or Member materials issued pursuant hereto.
- D. No interest in this Agreement nor in any materials issued pursuant hereto to Covered Person is assignable without written consent of the Plan being first obtained.
- E. No person other than a Covered Person is entitled to any benefit listed in the Member materials issued pursuant to this Agreement. The Member materials, including but not limited to the Member handbook, benefit summaries and Membership Card shall not be transferable and shall be forfeited if any Covered Person attempts to transfer them, or aids or attempts to aid any other person in obtaining any benefits under them.
- F. When applying for benefits or services under this Agreement, the Covered Person shall present the Membership Card provided by the Plan.
- G. All required notices shall be in writing and shall be deemed sufficient if sent by U.S. Mail. Notices to a Covered Person may be sent to the last known address of such Covered Person or to such Covered Person in care of the Group. Notices given to the Plan shall be sent to the offices of the Plan. Notices given to the Group shall be sent to the last known address of the Group. All notices shall be effective at the time of posting.

- H. The Group shall maintain records, satisfactory to the Plan, of the Subscribers and Covered Persons, showing with respect to each, information required in order to determine the existence of Coverage for any individual under this Agreement. The Group shall furnish on the Plan's forms such timely information relating to newly enrolled individuals, changes in classification, termination of Coverage and other changes relating to Subscribers and Covered Persons as may be required by the Plan to administer the Coverage provided under this Agreement.
- I. This Agreement shall be governed by and construed in accordance with the laws of the State of Indiana.
- J. The relationship between the Plan and Participating Providers is that of an independent contractor. Hospitals, Physicians and other Participating Providers are not agents or employees of the Plan, nor is the Plan an employee or agent of the Participating Providers. Participating Providers shall maintain professional patient relationships with Members and are solely responsible to Members for all medical and Hospital services.
- K. A Covered Person is responsible for presenting their insurance information to the provider at the time of service. Failure to do so within ninety (90) days will result in denial of claim for service.
- L. A Covered Person is responsible for presenting their insurance information to the provider at the time of service. Failure to do so within ninety (90) days will result in denial of claim for service.
- M. The Plan is a covered entity as defined in the Administrative Simplification Rules of the Health Insurance Portability and Accountability Act (HIPAA) and as a covered entity agrees to comply with such regulations involving privacy, security and standard transactions and code set regulations upon their respective compliance dates.
- N. The Plan has full, exclusive and discretionary authority to determine questions arising in connection with this Group Service Agreement. It is at the Plan's discretion to approve or deny benefits and administer this contract. This provision applies only where the interpretation of this policy is governed by the Employee Retirement Income Security Act (ERISA), 28 U.S.C.1001 et seq. This provision does not affect a Covered Person's right to pursue the Grievance Procedure or other legal remedies.

ARTICLE XI - GRIEVANCE PROCEDURES

The following Grievance Procedures are mandated by Indiana State Law.

A. Grievance Resolution

Questions regarding your policy or Coverage should be directed to:

**Customer Solutions Center
M•Plan
8802 North Meridian Street
Suite 100
Indianapolis, Indiana 46260-5371**

M•Plan's Customer Solutions Center: (800) 816-7526

If you

1. need the assistance of the governmental agency that regulates insurance; or
2. have a complaint that you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
311 West Washington Street,
Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461 or (318) 232-2395

Complaints can be filed electronically at www.in.gov/idoi

The Covered Person has the right to appoint someone else, including their health care Provider, to represent the Covered Person in the complaint and appeals process. The Plan shall process all claims, complaints and appeals in accordance with Section 503 of ERISA and the applicable regulations thereunder, or an other successor or applicable law.

* Above paragraph complies with State of Indiana Bulletin 128, effective 7-1-05.

B. Definitions

Grievance— A dissatisfaction expressed orally or in writing by or on behalf of an enrollee regarding a denial of a covered service or the availability, delivery, appropriateness or quality of Health Care Services once proper carrier/eligibility information has been established. A request to change a previous decision made by the organization. A member, member representative or practitioner may appeal any adverse decision.

Pre-Service Grievance— A request to change an adverse determination made by the organization for care or service that has not been provided to the member.

Post-Service Grievance– A request to change an adverse determination made by the organization for care or service already rendered.

Urgent Care/Expedited Appeal – A request to change an adverse determination made by the organization for care or service that has not been provided or care and service that are actively ongoing and to which the application of the time periods for making pre-service or post-service appeal decisions could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function if the care or service is not received.

C. Pre-Service Grievance

1. When a Pre-Service Grievance is received. A letter is sent to the Member within three (3) business days of receipt of the Grievance. The letter:
 - a. Acknowledges the receipt of the Member's Grievance.
 - b. Provide the member with information concerning the review process;
 - c. Submit the Pre-Service Grievance to a physician, psychologist or pharmacist not involved in any previous determination for a review of the relevant clinical information;
 - d. This reviewer then informs the Member in writing of the decision and the basis therefore, to either uphold the denial or to approve the grievance within five (5) working days after completing the investigation. Notice of appeal rights will be included, as well as who to contact for more information.
 - e. If the denial is upheld, the Grievance Analyst contacts the Member to schedule an appeal hearing. If the denial is overturned the Member is notified of the approval:
 - i. Members may request to appear before the Appeal Panel;
 - ii. Members may submit oral or written comments, documents, or other information;
 - iii. Members who cannot appear in person at the hearing may communicate with the Appeal Panel via conference calling or other appropriate technology;
 - iv. When a Member does not wish to participate in a hearing, the Appeal Panel will review the Appeal documentation and render a decision.
2. The Plan shall investigate the substance of the Grievance including aspects of clinical care involved.
 - a. Pre-Service Appeal
 - i. No Members of the Appeal Panel may be involved in any previous determination or are subordinates of any person involved in any previous determination.
 - ii. A Board Certified specialist of the same or similar specialty in Medical Necessity cases shall consult or participate in the appeal process when appropriate. This specialist shall:
 - (a) Have knowledge of the medical condition, procedures or treatment at issue;
 - (b) Are in the same licensed profession as the Provider who proposed, refused or delivered the health care procedure, treatment or service;
 - (c) Are not involved in the matter giving rise to the Appeal or the previous Grievance process; and
 - (d) Do not have a direct business relationship with the Covered Person enrollee or the health care Provider who previously recommended the health care procedure, treatment or service giving rise to the Grievance.
 - b. Grievance and Appeal
 - i. The Grievance/Appeal will be completed and the Member notified of the decision within twenty (20) business days of the request. Notification includes:
 - (a) The decision, in clear terms, with the benefits or clinical rationale;

- (b) A description of the next level of appeal, (External Review by Independent Review Organization and/or civil action under ERISA 502(a)) and any relevant written instructions;
- (c) Notice that civil action under ERISA 502(a) does not apply to employees of Church Groups or Federal, State, and Local Government.
- (d) A list of titles and qualifications of individuals participating in the review of the Appeal;
- (e) A statement of the pertinent facts of the appeal;
- (f) A reference to the Group Service Agreement or contract provisions that support the decision;
- (g) If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
- (h) Statement of any additional information that could be helpful in the outcome of the appeal' and
- (i) Instructions for requesting a written statement of clinical rationale and review criteria for cases involving a denial of medical services.

D. Urgent Care Appeal/Expedited Appeal

1. An Urgent Care Appeal/Expedited Appeal will be provided for requests for review of an adverse determination related to an illness, a disease, a condition, an injury or a disability that would seriously jeopardize the Covered Person's:
 - a. Life or health; or
 - b. Ability to reach and maintain maximum function
 - c. Requires medically necessary service within forty-eight (48) to seventy-two (72) hours.
2. Urgent Care Appeals may include Concurrent Care reviews as appropriate. Concurrent Care reviews concern an adverse determination of a request for benefits affecting an ongoing course of treatment taking place over a period of time or an adverse determination of a number of treatments.
3. Upon receipt of an Urgent Care Appeal from a Member or practitioner acting on behalf of the Member, the Plan shall:
 - a. Refer all documentation to a physician not involved in the initial decision who confers with appropriate specialists as indicated and make a decision on the Urgent Care Appeal/Expedited Appeal.
 - b. Notify the Member or practitioner verbally of the decision as expeditiously as the medical condition warrants, but no more than seventy-two (72) hours from the receipt of the Urgent Care Appeal/Expedited appeal;
 - c. Provide written confirmation of the Plan's decision to the Member and practitioner within two (2) business days of providing verbal notification of that decision.
4. Notification Letters are to include:
 - a. The decision, in clear terms, with the benefits or clinical rationale;
 - b. A description of the next level of Appeal, (External Review by Independent Review Organization and/or civil action under ERISA 502(a)) and any relevant written instructions;
 - c. Notice that civil action under ERISA 502(a) does not apply to employees of Church Groups or Federal, State, and Local Government;
 - d. A list of titles and qualifications of individuals participating in the review of the Appeal;
 - e. A statement of pertinent facts of the Appeal;

- f. A reference to the Group Service Agreement or contract provisions that support the decision;
- g. If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
- h. Statement of any additional information that could be helpful in the outcome of the Appeal; and
- i. Instructions for requesting a written statement of the clinical rationale and review criteria for cases involving a denial of medical services.

E. Post-Service Grievances and Appeals

1. Post-Service Grievance

At the time a Post-Service Grievance is received, the plan shall:

- a. Notify the Member in writing within three (3) business days that his/her Post-Service Grievance has been received;
- b. Provide the Member with information concerning the review process;
- c. Submit the Post-Service Grievance to an individual not involved in any previous determination for a decision once all relevant information is gathered;
- d. The grievance will be completed and the Member notified of the decision within twenty (20) business days of the request and appeal rights will be provided.

2. Post-Service Appeal

When a Post-Service appeal is requested by the Member:

- a. A letter is sent to the Member from the Plan advising the Member that the review will proceed to the Appeal level. The letter shall:
 - i. Provide the Member with information concerning the Appeal process;
 - ii. Offers the Member the opportunity to be represented by someone of their choosing (including a practitioner or Member representative);
 - iii. Offer the Member the opportunity to stop the review process if they so desire;
 - iv. Advise the Member of the following options:
 - Member may request to appear before the Appeal Panel;
 - Members may submit oral or written comments, documents, or other information;
 - Members who cannot appear in person at the hearing may communicate with the Appeal Panel via conference calling, video-conferencing or other appropriate technology.
 - When a Member does not wish to attend a hearing the appropriate Appeal Panel will review the Appeal documentation and render a decision.
- b. No Members of the Appeal Panel may be involved in any previous determination or be the subordinates of any person involved in the initial determination.
- c. A Board Certified specialist of the same or similar specialty in Medical Necessity cases may be consulted or participate in the Appeal process when appropriate.
- d. Letters to the Members of the Appeal decision shall include the following elements, when applicable:
 - i. The decision, in clear terms, with the benefits or clinical rationale;
 - ii. A description of the next level of Appeal, (External Review by Independent Review Organization and/or civil action under ERISA 502(a)) and any relevant written instructions;
 - iii. Notice that civil action under ERISA 502(a) does not apply to employees of Church Groups or Federal, State, and Local Government;

- iv. A list of titles and qualifications of individuals participating in the review of the Appeal;
 - v. A statement of the pertinent facts of the Appeal;
 - vi. A reference to the Group Service Agreement or contract, provisions that support the decision;
 - vii. If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
 - viii. Statement of any additional information that could be helpful in the outcome of the Appeal; and
 - ix. Instructions for requesting a written statement of the clinical rationale and review criteria for cases involving a denial of medical services.
- e. The Appeal review will be completed and the Member notified of the decisions no later than thirty (30) days from receipt of the Appeal.

F. External Review

Any Covered Person or his/her representative may file a written request for external review of a Grievance resolution decision with the Plan, at the aforementioned telephone number or address, no later than one hundred eighty (180) days after the Covered Person is notified of the Grievance resolution decision if it was a Grievance regarding:

1. An adverse utilization review determination;
2. An adverse determination of Medical Necessity; or
3. A determination that a proposed service is experimental or investigational (of a service proposed by the treating physician).

Resolution of an External Review must be completed within fifteen (15) business days after the Appeal is filed.

An Expedited Appeal will be provided for a Grievance related to an illness, a disease, a condition, an injury or a disability that would seriously jeopardize the covered Person's:

1. Life or health; or
2. Ability to reach and maintain maximum function.

Resolution of an Expedited External Review must be completed within forty-eight (48) to seventy-two (72) hours after the Appeal is filed.

For Services received over twelve (12) months prior to the date of the grievance filing, the Member is responsible for obtaining all relevant information.

A Covered Person cannot file more than one (1) Appeal of the Plan's Grievance resolution decision. All Costs will be paid by the Plan. The Plan shall provide a procedure for reconsideration if new evidence for consideration is submitted to the Plan during the External Review process. The decision of the External Reviewer shall be binding on the Plan but not on the Covered Person. If the Covered Person has the right to an external review under Medicare, the Covered Person may not request an External Review under this process.